

**HEALTH CARE REFORM
(Part 8)**

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Health Care Reform, (Part 8), Seria...

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
SECOND SESSION

JANUARY 26, 1994—WOMEN'S HEALTH
JANUARY 31, 1994—PUBLIC HEALTH, CONSUMER PROTECTION, CIVIL
AND PRIVACY RIGHTS
FEBRUARY 1, 1994—ALTERNATIVE LEGISLATIVE APPROACHES

Serial No. 103-109

Printed for the use of the Committee on Energy and Commerce



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HEALTH CARE REFORM

Women's Health

WEDNESDAY, JANUARY 26, 1994

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.**

The subcommittee met, pursuant to notice at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. Good morning. Today's hearing is on women's health and health reform. Since women make up almost 52 percent of America, it could, of course, be said that all health issues are women's health issues. But in addition to their general health care needs, women have a number of specific needs and problems that are different from the needs and problems of men or children.

For years, this entire discussion of women's health was occupied solely by debates about reproductive health. Women were viewed as needing family planning services, abortion services, and prenatal care and whatever men needed. Unfortunately, these reproductive health needs have never been satisfactorily addressed and they will continue to be an issue in health reform.

But fortunately, the Clinton health reform plan does recognize that women have other specific needs: Women need mammography, they need Pap smears, they need long-term care for themselves and for the family members they end up caring for.

Because women are more likely to be caregivers for their families, they need transportation and child care and the range of enabling services that turn a health care card into true access. And because women are more likely than men to be poor and less likely to be privately insured, women need access to basic services regardless of where or whether they are employed.

The Clinton health care plan meets these needs. It does, of course, cover all reproductive health care services, including a woman's right to plan her pregnancy and receive prenatal and postnatal services and to terminate her pregnancy. But it also provides clinical prevention services for breast and cervical cancer screening. It provides a limited long-term care benefit. It provides for social and support services and most crucially it provides universal coverage for all Americans.

The debate about health reform is about a huge segment of the economy, about numbers, and about markets. But fundamentally it is a debate about people, and most of the American people are women. In that vein, it is not possible to say that one supports

women's health but opposes comprehensive health reform. They are interchangeable and, therefore, it makes perfect sense that the year following the electoral Year of the Woman should be the political Year of Health Reform.

We have a number of witnesses to testify before us today. We are looking forward to hearing from them but before we call on our witnesses, I want to recognize members of the subcommittee, and to start off, the Ranking Republican of this subcommittee, Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. Before I begin my remarks about the subject of today's hearing, I would like to make some general comments about the President's threatened veto of any health care bill which does not provide universal coverage by, one, nationalizing the American health care system under the control of Federal bureaucrats; two, imposing an employer mandate with a new 7.9 percent payroll tax; three, limiting American's choice of physician by ultimately placing every American in large HMO's; four, funding a large part of the expansion of coverage through draconian cuts in Medicare and Medicaid which will destroy these programs; and, five, rationing health care by applying a global budget and price controls that will create in this country a tighter spending system than that of any other western nation.

As we begin the congressional debate about health care reform, the President's threatened veto is uncalled for and deeply disturbing. Rather than responsibly attempting to establish bipartisan reform which will fix the problems in the insurance marketplace that the President himself identified in his speech, such as preexisting conditions, guaranteed issue and renewability, and continuity of insurance coverage, he would rather hold out for a nationalized command and control, one-size-fits-all health care system which relies on rationing care and limiting individual choice.

The only two bills which meets the President's criteria are his Health Security Act and the McDermott Canadian single-payer bill, and we know that our Canadian neighbors had to shut down their hospitals during Christmas for 3 weeks because the government ran out of money.

The President's veto threat also attempts to make Republicans and conservative Democrats irrelevant in this debate. Along with many of my colleagues on this committee, we have worked over 2 years on the Republican health task force to craft H.R. 3080, action now which addresses insurance and malpractice reform, Medicaid reform and administrative simplification.

We also know that our respected colleague, Mr. Cooper, has been working with a bipartisan coalition to craft a managed competition bill. The President's message to all who believe in an incremental approach to health care reform is, don't bother to talk to us because I am vetoing any bill which does not immediately nationalize the system.

Republicans on this committee find that unacceptable. We hope in the coming weeks to work with Members from both sides of the aisle on a health care reform proposal which would build on the strengths of the current system, which is the best in the world, and fix only the problems that need to be fixed. If the President wants to ration health care, limit patient choice, create new payroll and individual taxes, and turn the American health care system into a

second rate one, he will do it, but not without a fight from this side of the aisle.

Mr. Chairman, I ask unanimous consent to revise and extend.

Mr. WAXMAN. Without objection, that will be ordered. Thank you very much, Mr. Bliley.

[The prepared statement of Mr. Bliley follows:]

STATEMENT OF HON. THOMAS J. BILEY

Mr. Chairman, the Clinton health care bill purports to provide universal coverage. I agree that under the Clinton bill everyone will have a "health security card." But at what price? Throughout our hearings on this bill, I have continually pointed out several aspects of the bill which lead me to the conclusion that the Clinton bill achieves universal coverage only through the rationing of care.

First we have the consumer price index (CPI) premium cap which would create a tighter spending control system than that of any other western nation. We know that in countries like Britain and Canada that price controls and global budgets lead to health care rationing. On Monday, we witnessed ourselves the news casts from Canada describing the hospital closures due to budget shortfalls. Yesterday, we pointed out the link between limiting the number of medical specialists and the rationing of high-tech specialty care.

And once again today, we must address the topic of rationing. The Clinton bill provides coverage for mammograms and Pap smears. However, women under the age of 50 are not eligible for mammography coverage. Yet according to the National Cancer Institute, breast cancer is now the leading cause of death in women ages 40-44.

In terms of Pap smears, the Clinton bill only provides coverage for a Pap test and pelvic exam every 3 years with certain exceptions. According to the NCI, the incidence of invasive cervical cancer has decreased in the United States over the past several years, largely due to early detection by the Pap test. However, over 13,500 American women are expected to be diagnosed with invasive cervical cancer in 1992, and an estimated 4,400 will die. How many more women will be added to these numbers because the cancer was not detected early?

Not only will many women be diagnosed in more advanced stages of disease, but due to the price controls in the bill breakthrough treatments may be unavailable to them. According to Professor John Lott of the Wharton School, "For drugs, controls will reduce the number of new drugs, with the resulting loss of lives those drugs would have saved." He goes on to say, "Even when people realize that controls are preventing new drugs from being developed, it will be very difficult to remove these controls."

Evidence of how right Mr. Lott is was presented recently at a conference sponsored by the Congressional Biotech Caucus. At that time Dr. Curd from Genentech stated that Genentech is on the verge of a breakthrough drug for breast cancer and that research on this drug would be in serious jeopardy if the Clinton bill passed primarily because of the price controls.

Now I would like to turn my attention to the inclusion of abortion in the standard benefits package. Last June when the President asked some of us for our input and ideas about how we could work together on health care reform, I cautioned the President that the inclusion of abortion could derail the entire reform effort. It is extremely disappointing that the administration made a decision based on politics and not on health care. Since 1980, the Supreme Court has recognized that "Abortion is inherently different from other medical procedures." We know that abortions are rarely performed for medical reasons. It is extremely disappointing that the administration has chosen that path.

According to poll after poll of what the public thinks should be covered by a basic benefit package, most Americans do not support coverage of abortion. Let me quote Gregg Erlanson, editor-in-chief of "Our Sunday Visitor", the Nation's largest Catholic publishing house. He states in a Wall Street Journal editorial, "However divided the country may be about whether abortion is an ethical public policy, a consensus has emerged on the matter of public payment for abortion. If abortion is a choice, it is a private choice, and payment for it should be left to the individual."

The Clinton health plan forces everyone who is morally opposed to abortion to pay for it. As we examine the administration proposal, the American people must not be under any illusion about abortion coverage. The administration smokescreen on abortion hides the facts. The President personally told the American people that they will be able to choose plans which do not cover abortions. But under H.R. 3600, there simply will not be any such plans to choose.

Under the Clinton bill on page 95, "A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction." So a Catholic hospital does not have to perform abortions, but it must purchase a health insurance plan that covers abortion and it must pay for that coverage. The so-called conscience clause does not apply to health plans so abortion must be included in every health plan offered. Even if every employee of that same Catholic hospital was opposed to abortion, it would still be paying for abortions because of the tremendous amount of cross-subsidies in the Clinton bill.

From a public financing perspective, the Clinton health care plan represents an enormous expansion for the public payment of abortions. According to a 1990 American Journal of Public Health Survey, only seven States pay for abortion on demand. In 29 States, public financing was limited to the rare circumstances in which the life of the mother was threatened. This legislation opens the floodgates for public financing of abortion on demand. This not only offends the consciences of millions of the living, it will likely mean the death of even more unborn Americans.

It is indeed unfortunate that the administration has placed the political interests of a few above the moral reason of the rest. Given the restrictions on State and Federal funding for abortions, it is clear that the majority of Americans reject funding for abortion on demand. The inclusion of this divisive provision confirms the fears of many of us that H.R. 3600 is more about government power than it is about health care.

Over the years, I have consistently supported increased funding of maternal and child health care services for those families who lack sufficient resources. I have introduced my own legislation and have supported Members on both sides of the aisle to ensure that no women would be faced with choosing abortion over birth because of an inability to pay for medical care. I renew my pledge to close the gaps in our health care service delivery system. But there is not reason or justification that generations to come must be sacrificed to attain that goal.

Mr. WAXMAN. I want to recognize, to start off, the opening statements on the Democrat side, the very distinguished Member of Congress from the State of Illinois, and chairman of one of our subcommittees of the Energy and Commerce Committee, which is very much involved in the health care reform, Mrs. Cardiss Collins.

Mrs. COLLINS. Thank you very much, Mr. Chairman. I want to thank you, too, for inviting me to accompany your subcommittee for today's hearing.

The subject of women's health has been near and dear to me for many years and never has it held our attention as much as now. The inadequacies of the Nation's health care delivery system are better defined than ever before, and the research that has scrutinized the status of women's health has revealed significant shortcomings.

Due to the national sentiment and the efforts of the President and the Congress to pass comprehensive health reforms this year, we have a watershed opportunity to make wholesale improvements in the health of America's women and, through prenatal care, future generations. We must make sure that 1994 is remembered as a landmark year when Congress answered the call of our mothers, sisters, wives, and daughters by doing all that it could do rather than surrender success to politics as usual.

Over the years, I have been devoted to enhancing women's health in a variety of spheres. I was appalled that the Medicaid and Medicare programs failed to provide their recipients with coverage for mammograms and Pap smears for the early detection of cancer, and I set about to rectify that. Although these programs have improved with respect to coverage of these tests for diagnostic purposes, they sometimes suffer from a failure to cover them as preventive screenings.

Considering that there are, for example, an estimated 8,700 new cases of breast cancer each year in Illinois alone, and approximately 2,200 Illinois women are expected to die from this disease this year, we must recognize the value of these tests as preventive screenings and institutionalize coverage of them.

Other measures that have been of great concern to me over the years have included a greater role for nurses in the health care delivery network, an expansion of research and funding for research on women's health, appropriate inclusion for women in clinical drug trials, and the continued expansion of all reproductive health services for all women. We have come a long way, but, unfortunately, there remains a lot of ground to cover still. Once again, 1994 offers a unique chance to embrace long overdue solutions.

First and most importantly, the President's emphasis on universal coverage is especially crucial for women. Today's voluntary, employer-based system of health coverage is disadvantageous for part-time and temporary workers and employees of small businesses are commonly uninsured or underinsured.

Women are disproportionately affected by these gaps. For example, roughly $\frac{2}{3}$ of all part-time workers are women and only about 25 percent of women who work for companies with less than 25 employees have employer-based health insurance. Certain types of businesses, many of which hire women more often than not, are even less likely to contribute to health benefits for their employees.

All of these and other coverage deficiencies especially hurt poor working and nonworking women, and I will not let them be forgotten in the course of health care reform.

Second, it is imperative that the coverage that women do have is sufficient in light of our distinct health needs. Early detection screenings, such as mammograms and Pap smears, must be fully covered for all women in the age groups that are most susceptible to breast, cervical and uterine cancers.

The full range of reproductive health care, including prenatal, postnatal, well-baby and family planning services, must be covered for all women regardless of employment, income, or other factors.

It has been shown that babies born to mothers without health insurance are 30 percent more likely to die or to be seriously ill than those whose mothers have not. There is simply no acceptable justification for perpetuating this disparity. The economic consequences of this contrast are also compelling, as each low birth weight baby costs our health care system an additional \$14,000 to \$30,000 beyond the costs associated with healthy babies.

In addition, access to as broad a range of providers and medical facilities as possible should be assured, so as to increase the number of caregivers and make preventive and other health services convenient enough to facilitate their use.

Full information must be provided to women about their health care decisions in order to enable women to give an informed consent and avoid tragedies such as occurred with regard to breast implants. Health education, wellness programs, and data on health and illness should be promoted and made as widely available as practical.

All in all, Mr. Chairman, the agenda for the improvement of American women's health is long. That is due to an inadequate de-

gree of attention that these issues have received in recent years, but it is that much more imperative that the needs be satisfied in the short term.

I am optimistic that we can unite to advance the health of our mothers, wives, sisters, and daughters for generations to come through 1994's landmark legislation on health reform. I will look forward to support for these concerns from all of my colleagues, Mr. Chairman. And in the interest of saving time, I ask unanimous consent that my entire statement be made a part of the record, and I, again, thank you, Mr. Chairman, for inviting me to be a part of this hearing and yield back the balance of any time that I might have.

Mr. WAXMAN. Thank you very much, Mrs. Collins.

[The opening statement of Mrs. Collins follows:]

STATEMENT OF HON. CARDISS COLLINS

Thank you, Mr. Chairman, for inviting me to accompany your subcommittee for today's hearing.

The subject of women's health has been near and dear to me for many years and has been the focus of many of my efforts. Yet, in my 20 years of service in the House of Representatives, never before has it impelled our attention as much as it does now. The timeliness of this subject is partly because the inadequacies in our Nation's health care delivery system are better defined than ever before, and the research that has scrutinized the status of women's health has revealed significant shortcomings. At the same time, this subject is also timely because of the national sentiment and the efforts of the President and Congress to pass comprehensive health reforms this year. As a result, we have a watershed opportunity to make wholesale improvements in the health of America's women and, through prenatal care, the health of future generations. We must make sure that 1994 is remembered as a landmark year when Congress answered the call of our mothers, sisters, wives, and daughters by doing all that it could do, rather than surrender success to politics as usual.

Over the years, I have been devoted to enhancing women's health in a variety of spheres. I was appalled that the Medicaid program failed to provide its recipients with coverage for mammograms and Pap smears for the early detection of cancer, and I set about to rectify that. Although Medicaid has improved with respect to coverage of these tests for diagnostic purposes, it still suffers from a failure to cover them as preventive screenings. The distinction between diagnosis and prevention is an important one. By only covering visits on a diagnosis basis, we are inhibiting many poor women from going to their doctors for Pap smears and mammograms on a regular basis, as suggested by the guidelines established by the American Cancer Society and the American College of Obstetricians and Gynecologists. African-American women who are Medicaid recipients are particularly disadvantaged by this Medicaid policy because, although they have a lower incidence of breast cancer, studies show that African-American women are more likely to die from this disease due to receiving fewer mammograms and, therefore, not detecting the disease until it is in its more advanced stages. You can be sure that a chief reason that they do not receive these important screening tests more regularly is that they cannot afford them.

Considering that, for example, there are an estimated 8,700 new cases of breast cancer each year in Illinois alone, and approximately 2,200 Illinois women were expected to die from this disease last year, we must recognize the value of these tests as preventive screenings and institutionalize coverage of them. To bring additional attention to the need to facilitate the access of women to regular mammograms, I have sponsored a resolution to declare October "National Breast Cancer Awareness Month" for each of the past 4 years. Also, I am very pleased that last year's reauthorization of the National Institutes of Health included a greater emphasis on this disease.

Other measures of great concern to me over the years have included efforts to expand the role of nurses in the health care delivery network, including reliance on RN's as first assistants at surgery as well as all specialized nurses for their areas of expertise. I have been an advocate for increases in funding for research on all aspects women's health, including both those diseases or conditions that are unique to women and those which simply require different treatments or interventions for

women. The appropriate inclusion of women in clinical drug trials has become important more recently, as we have learned that many drugs and devices failed to take into consideration the unique needs and responses of women. And, of course, I have been a very long, dedicated and steadfast supporter of the continued expansion of all reproductive health services for all women. We have come a long way, but, unfortunately, there remains a lot of ground to cover. Once again, 1994 offers a unique chance to embrace long-overdue solutions.

With regard to changes which we must strive to effectuate in 1994, first and most importantly, the President's emphasis on universal coverage is especially crucial for women. Today's voluntary, employer-based system of health coverage is disadvantageous for part-time and temporary workers because they are the most likely workers to be excluded from their employers' health care programs. In addition, employees of small businesses are commonly uninsured or underinsured, as their employers are the most likely employers to offer only barebones coverage with high deductibles or simply skip it altogether.

Women are disproportionately affected by these gaps. For example, roughly $\frac{2}{3}$ of all part-time workers are women, and only about 25 percent of women who work for companies with less than 25 employees have employer-based health insurance. Certain types of businesses, such as those engaged in sales, and household services—many of which more often hire women than men—are even less likely to contribute to health benefits for their employees. All of these and other coverage deficiencies especially hurt poorer working and non-working women, and I will not let them be forgotten in the course of health care reform.

Second, it is imperative that the coverage that women do have is sufficient in light of our distinct health needs. Early detection screenings, such as mammograms and Pap smears, must be fully covered for all women in the age groups that are most susceptible to breast, cervical and uterine cancers, as I discussed earlier.

The full range of reproductive health care—including prenatal, post-natal, well-baby and family planning services—must be covered for all women, regardless of employment, income, or any other factors. This is an area where it is especially important that pontification give way to strictly health-based considerations. It has been shown that babies born to mothers without health insurance are 30 percent more likely to die or be seriously ill than those whose mothers do have it. There is simply no acceptable justification for perpetuating this disparity. The economic consequences of this contrast are also compelling, as each low birthweight baby costs our health care system an additional \$14,000 to \$30,000 beyond the costs associated with healthy babies.

In addition, access to as broad a range of providers and medical facilities as possible should be assured, so as to increase the number of caregivers and make preventive and other health services convenient enough to facilitate their use. Full information must be provided to women about their health care decisions in order to enable women to give an informed consent and avoid tragedies such as occurred with regard to breast implants. Health education, wellness programs, and data on health and illness should be promoted and made as widely available as practicable.

All in all, Mr. Chairman, the agenda for the improvement of American women's health is long. Due to the inadequate degree of attention that these issues have received in recent years, it is that much more imperative that the needs be satisfied in the short run. I am optimistic that, through 1994's landmark legislation on health reform, we can unite to advance the health of our mothers, wives, sisters, and daughters for generations to come. I look forward to support for these concerns from all of my colleagues and I thank you again, Mr. Chairman, for inviting me to take part in this hearing.

Mr. WAXMAN. I am pleased now to recognize the Ranking Republican of the full Energy and Commerce Committee, Mr. Moorhead.

Mr. MOORHEAD. Well, thank you, Mr. Chairman.

Today's hearing focuses on the impact of the Clinton health plan on women's health. Again, I must express my concern that the administration's plan is promising things it cannot deliver. The health of women in America is not going to be helped by a plan that ultimately rations care and destroys the ability of the pharmaceutical and biotechnical industries to pursue innovative new therapies.

I strongly support research and everything that can be done to develop answers to women's health problems. I strongly support

availability of Pap smears and mammograms, prenatal and post-natal care for women. Most of us who are married are very concerned about what can happen to our wives and we want all the research done that can find answers to these serious problems of breast cancer and uterine cancer and the other things that our friend's wives and others are getting that destroys their lives.

I must, however, take exception to including voluntary abortions in the basic benefit package. Obviously, this is one item that could not be passed on its own. According to poll after poll, Americans do not support Federal payments for abortion. For example, The New York Times CBS poll in April 1993 found that only 23 percent said it should cover abortion, while 72 percent said that these costs should be paid directly by the woman.

An ABC Washington Post poll in July 1992 found that 63 percent of those earning less than \$15,000 a year opposed Federal funding of abortion. An NBC poll in September 1993 found that 52 percent of those polled felt that health care reform should not include coverage for abortions.

I think that this money that is going to have to be paid for abortion will come out of the funds to be used for other kinds of research to help women and others get quality health care. I think it is a mistake to have this extra burden to the health care program and to this bill as it struggles through the Congress. I totally associate myself with the comments of the gentleman from Richmond.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Moorhead.

Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman. I want to commend you for all the leadership you have shown on this issue over the many years, and also say I look forward to our quartet of colleagues that have been out there on the front lines fighting for many years.

Mr. Chairman, let me, if I might, make three points. This committee will be the first in the Congress on either side of the Capitol to go on record on the critical issue of whether abortion should be in the basic benefit package under national health reform. I think it is absolutely critical abortion be in that basic benefit package because the fact is if it is not, we will be retreating from the rights women now have under the law.

The fact of the matter is that abortion is legal in our country. The fact of the matter is that abortion is covered for millions of women under private health insurance, and if it is not in the basic benefit package, we will be retreating in this Congress from the rights women now have under the law.

Toward the end of making sure that abortion is covered, Congresswoman Collins, who has been working hard with us, and a very able woman on the committee, and I, are circulating a letter that I invite all members of this committee to join with us in signing to the President urging that abortion coverage be kept in this legislation. Since this committee is the first to go on record on this issue, the fight to make sure that this important benefit is included really starts right in this room.

The second point that I would make, Mr. Chairman, deals with the importance of contraceptive pricing for women. I would like to show my colleagues one of the promising contraceptives: Norplant. This drug was developed to a great extent with taxpayer money. But right now in the United States it costs \$365, while overseas it costs about \$23. The fact is the taxpayer subsidized the development of Norplant. We now spend \$4.5 million through foreign assistance so that women overseas can get Norplant, while women wait in line for this contraceptive in our country.

Recently we asked Wyeth if at a minimum—and Wyeth is the maker of this drug—they could give a discount to the public clinics. Wyeth said, and I quote, “If the drug came to be simply seen as a product for public sector clinics and low-income users, we knew it would not be well-accepted.” So, in effect, what you are seeing is drug companies in this country taking taxpayer money and then price gouging public programs like our family planning programs because they are afraid that affluent women would not use it.

So we have to make sure in this national health bill that the pricing of contraceptives for women, and of course contraceptives are key to reducing abortions, is done fairly.

Mr. Chairman, I look forward to working with our colleagues and thank you for the chance to participate.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Greenwood do you want to give an opening statement?

Mr. GREENWOOD. No, thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Towns, an opening statement?

Mr. TOWNS. Yes, thank you very much, Mr. Chairman.

Let me begin by saying that I really appreciate the leadership that you have shown in this area, and I look forward to working with you in terms of hammering out some legislation that we will all be proud of at the end. I will be brief because I am anxious to hear my colleagues.

A variety of health care groups, from the Black Women's Health Project to the American College of Obstetricians and Gynecologists, have called for basic health coverage for women that include the following: annual pelvic exams; gynecological visits with no age limitations; annual clinical breast examinations with no age limitations; Pap test coverage annually, except for women who have negative tests for 3 years consecutively, with no age limitations; mammograms every 2 years for women between 40 and 49 and annually for women over 50; reproductive rights, including abortion.

This list is, in my mind, basic health care for women. We cannot provide any less. When we talk about health care reform, the objective is to improve health services for all Americans. Let us not be confused. Reform is not just cutting costs, it is about providing better health care for all Americans.

Indeed, the easy part is to cut costs. All you have to do is just eliminate a Pap smear over there, eliminate a pelvic exam over there and a few more over here, and eliminate mammographies for women under 50 and just keep eliminating and of course you will be able to save costs. But at the same time you would be able to destroy a lot of people, and I think that is not the way we want to go.

But then what kind of improved health care are we providing the women of America? I think that is the real question. Without mammography coverage, what form of early detection are we providing next year's 12,000 women under 50 who will contract breast cancer? What about black and Hispanic-American women under 50 who are dying at increasing rates from breast cancer? How can we eliminate the most effective early detection technique available to these women when breast cancer is the number one cancer causing death for African-American women under 50 years old? I am talking about the survival of women in this country.

The National Cancer Institute—I have a chart here published by the National Cancer Institute that shows the difference in size between a lump detected by routine mammography and a routine breast self-exam. The difference in the screening techniques is astonishing. Early detection through mammography actually makes a difference.

Let me show this. This you cannot probably see, but let me show you this one you can see. Average size lump found by getting regular mammograms is this size. Average size lump found by first mammogram is this size. Average size lump found by women practicing regular breast self-examination is this size. Average size lump found by women practicing occasional examination is this size. I think that is very, very, very significant.

In real terms there is a difference between being able to find a raisin and a golf ball. That is the difference. And for people to sort of like pass this off and not pay attention to this, to me, is very disturbing. If we eliminate early detection for young women, we put the lives of these women at an increased risk.

I represent a district that is predominantly Hispanic and African-American, and I cannot sit here and allow the future health of American women to be jeopardized simply to generate increased health care cost savings. This is the wrong way to go, and I hope that if we are talking about serious health care reform we will talk about putting forth a program that will save lives, not destroy lives.

Thank you very much, Mr. Chairman, and I yield back the balance of my time.

Mr. WAXMAN. Thank you, Mr. Towns.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. I would just like to add my strong support for the committee's work to ensure that reproductive health rights are part of the rights that are recognized and included in the health benefits package of the reform bill that I trust we produce on the 4th of March.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Brown.

Mr. BROWN. No opening statement, Mr. Chairman. Thank you.

Mr. WAXMAN. Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman. I appreciate your leadership on a whole range of issues but especially in the health care area.

I would like to clarify for a moment what is in the bill, H.R. 3222, the so-called Cooper-Grandy/Breaux-Durenberger bill. We felt

for some time there was a fundamentally procedural question as to how Congress should deal with the definition of a basic benefits package. And while it is tempting and there are many positive arguments to say we should specify a specific package, 66 pages long, 100 pages long, whatever, we are worried that with so few health professionals in this body and with such a limited time constraint, that it may be not the best way to solve the problem.

So we have thought that it would be better to turn it over to a panel of experts chosen by the President, chosen in a way that groups across America feel that top flight health care professionals are represented so that they can use their considered judgment as to what is best to help real people. We do have broad guidelines in our bill. We specify that this expert panel would have to include a full range of preventive services in the definition of any package.

We think they should include anything that is medically appropriate, but our feeling was that Congress should listen to the recommendations of the expert panel and then vote yes or no on the entire package, without amendment, the so-called "base closing procedure" or the procedure we have used on several other very important measures. We are worried about politicizing the definition of a basic benefits package. We are also worried about making it an unscientific package, and thus our feeling that the best way to avoid these pitfalls was to rely heavily on expert advice in these very complicated areas.

But I want to work with the various groups to make sure that we are sensitive to all the human needs out there, to make sure that we may need to come up with an interim benefits package, for example, to make sure people have the feeling of certainty to know what is in the package that we are considering, but I would hate to freeze science at any particular level. I would hate to take a step that might overly politicize or render unscientific a basic health benefits package.

But this will be one of the fundamental procedural questions we will face in this year's debate. It will be interesting how we handle it. States have been wrestling with these issues for many years. And just to use a reference, the Tennessee eye care. We had a major battle royal in last year's legislature between optometrists and ophthalmologists over Tennessee eyeballs. And one side prevailed, and perhaps the right side prevailed, but few folks were qualified to read the clinical studies indicating who is, in fact, the best at providing the best, most cost-effective care for Tennessee eyes.

So it is one of the fundamental questions, and, as I say, I am looking forward to working with all the different groups to come up with the best possible solution in this area.

Thank you, Mr. Chairman, for yielding the time.

Mr. WAXMAN. Thank you very much, Mr. Cooper.

Ms. Schenk.

Ms. SCHENK. Thank you, Mr. Chairman. First of all, I want to also commend you for your leadership on these important issues for the many years that you have fought for them in California and here in Washington. I am proud to be a fellow Californian serving with you.

Also want to thank you for extending to me the courtesy of sitting in on this hearing. It is obviously of great personal interest as a woman, it is of interest to me as a daughter, as a friend, as a sister-in-law, and as one of the 52 percent of the population in this country.

I just want to make one very quick statement, particularly in light of the fact that we have such a distinguished panel before us and I am honored to be here with them. Abortion is an absolute fundamental component of women's health care and it is a fundamental component of a woman's ability to control her own life. Since it is such a basic, it is an issue that should be clearly, clearly included as a basic in the health plan that comes through this committee and through the Congress and we should not try to in any way say it in any fancy language, in any bureaucratic language, in language of the Beltway, it is fundamental to women, it is basic to women, and without it there is no health plan.

So thank you very much for, again, Mr. Chairman, for allowing me to participate.

Mr. WAXMAN. Thank you very much, Ms. Schenk.

Ms. Margolies-Mezvinsky.

Ms. MARGOLIES-MEZVINSKY. Thank you, Mr. Chairman. I would like to echo what has been said by others here. I welcome these hearings. I would like to applaud your interest in them, and I think in the interest of time we should move on. I yield back the balance of my time.

Mr. WAXMAN. Thank you very much.

Mr. Sharp.

Mr. SHARP. Thank you, Mr. Chairman. I have no opening statement.

[The prepared statement of Mr. Synar follows:]

STATEMENT OF HON. MIKE SYNAR

I am extremely pleased that we are holding this hearing on health care reform and women's health. For too long, women have been seen as an inconsequential blip in the field of health care. Even today, we will hear the testimony of women as though they are a special group. In a sense they are, as women have health needs that are distinctly different from those of men. But women are not a minority, and health care reform must recognize women, who indeed outnumber and outlive men, as an integral part of the success of any health care system in our country. Although hearings addressing women's health are especially important during the crafting of any type of legislation such as the Health Security Act, hopefully, this country will soon reach a time where representing and fighting for women's health interests is a given.

Indeed, we are especially lucky to have several women who serve in Congress and are effective advocates for women's health and reproductive freedoms. Not only are women our wives, daughters and sisters, but they are our Congresswomen and Senators who are ready and willing to speak for their nationwide constituencies of women, whose concerns oftentimes had gone unheard. Thank you for testifying today.

We will also hear today from general women's health organizations, breast cancer groups and reproductive rights organizations. I look forward to their testimony on subjects that effect every woman intimately, as I know that every woman has the fear that she might be presented with one of these health problems, whether it be breast cancer or an unwanted pregnancy. The views presented here today will play a large part in my consideration of health reform, and the care it guarantees women.

Mr. WAXMAN. We are pleased to welcome for our first panel of witnesses, the distinguished group of our colleagues in the Con-

gressional Women's Caucus, Representative Pat Schroeder and Representative Olympia Snowe are Co-Chairs of the caucus; Representative Louise Slaughter, Chairperson of the Women's Caucus' Health Task Force; and Representative Nita Lowey, who Chairs the caucus' Reproductive Choice Task Force.

We are pleased to have you here today to talk about some of these very important issues which are very much part of health care reform, and we have to be mindful of the impact of health care reform on these issues.

Mrs. Schroeder, we would like to start with you, and you can all proceed with your statements. Let me indicate your prepared statements will be in the record in full. We would like to ask, if you would, to limit the oral presentation to 5 minutes.

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mrs. SCHROEDER. Thank you very much, Mr. Chairman. I will put it in the record.

I want to say how wonderful it is to see our women colleagues on this committee in helping, but I also want to underline over and over again, this panel would all say to you, Mr. Chairman, that you have been the prime cosponsor of everything we have done, and we are here in force today because we do not want to lose the ground you and the rest of us have attained on women's health.

As you know, women's health was in the dark ages. You helped us get all of those studies to show it and you helped us move the legislation and get it signed. We thank you. You have really put your whole self into this project and we are here because we are terrified that the health care train is going to leave the station and women are not going to be on it in equal seats. And if that happens, we are going to be chasing that train for another 20 years to get on it, and I think most of us do not want to see that happen. We want on that train and we want to be on there with the same kind of treatment men have: Whatever is medically necessary and appropriate.

Those are the magic words. If men listened to this group sit around here and talk about how many PSA's we were going to let them have after age 50, I think they would get pretty mad. I think they would say, what are these women talking about; we want doctors to make that decision. Let me tell you women want doctors to make that decision and not policymakers. So that is why we are here.

Let me put a few things out on the board. Number one, we do now allow Federal compensation, in a way, for abortion. It is in health care policies that almost every woman has because if it is considered medically necessary and appropriate, it is covered by their health care policy. And guess what? Health care policies are deductible from Federal income tax. That, to me, looks like as much a subsidy as the other kind. We have kind of lectured to poorer women but they have been afraid of middle class women. Let me tell you, if middle class women find out that this group has changed their coverage, they are not going to be happy.

Second, we have had the experience with what has happened to poor women when we started playing these games and found that

poor women then could not even get good family planning services because we let people redefine family planning to be natural family planning. Well, what is that? Hey, that is the rhythm system, and in Colorado we call people who use that parents. That is what happens. People start saying, well, oh, then abortion, then abortifacient and then the gag rule, then—the Women's Caucus has put out a set of principles we believe must be in the health care policy. It is in my testimony. I won't read it again. I think most of you endorse it, but it says we are full citizens and we want to be treated the same as any other citizen.

I must say this is absolutely critical for women because they tend to need health care much earlier on. When their reproductive system kicks in, it is a very good time to get every woman in a doctor's office. And yet if you look at the number of women not covered in that age group, it is very, very high and it costs us a lot of money, something like \$2.4 billion a year for pregnancy services in emergency rooms because people did not have it.

Then it costs us even more because they did not have prenatal care and we could go on and on. Why? Because most of the women who do not have it are employed but they are employed in part-time and temporary work. That is the new escape clause, to escape having insurance. So we really think this universal coverage is so important for women. And covering part-time work is so important for women because, otherwise, they predict by the year 2000 half the jobs in America will be part-time without health care insurance and most of the people who will have them will be women and they will be of childbearing age.

That is our future. Children. And if we do not care about the mother, then we don't end up with a healthy baby, and if we have not got the mother in the health care system, how does she plug the baby into the health care system? And we know those statistics. We have some of the worst statistics on the planet about that. So this is about getting habits, getting habits early on. Taking care of those habits.

Then the next big problem is teens. We have to also make sure that teens are covered in this package because we know 10 to 18-year-olds tend to drop out of the health care system, both as men and women, and we know that this government has hesitated very much to talk about it because a certain group says when you say "teen" and you say "health", they hear, "We are on puberty." Yet when you are a teen, that is when you get your smoking habits, that is when they get drinking habits, drug habits, exercise habits, eating habits and, of course, sex does kick into their life, especially for young women with their reproductive organs. Very important to have exams then. HHS has some now interesting studies showing that teens who remain with a doctor during those important years are much less apt to smoke, much less apt to be pregnant, much less apt to have all sorts of problems.

So we need to develop a way where teens are going to also be able to talk to doctors and get their habits right or we can forget calling this preventive anything because we have to then undo all the bad habits they learned in that very important time.

I could go on and on and on. I won't because I know you all know what this is about, but this is really about saying we must have

women included equally. I must tell you I was totally dismayed to read in the national magazine last week that one of the proposals some of our colleagues are proposing and that is to let women get private insurance for their private parts.

Now, I find that absolutely totally unacceptable. We would never say to men, you know, you just have to get private insurance for your private parts because there are a few of us that don't want to pay for PSA's or for this or that. Can't we be adult about this? Can't we trust the medical profession to say what is medically necessary and appropriate?

When you hear those polls that were cited earlier on, I want to correct that, because what happens is, if you ask people medically necessary and appropriate, they are very sympathetic. If you treat abortion or family planning services like cosmetic surgery, like women are going to go in every week and get one because they are now free or women will go get all the Pap smears they want or all the mammograms because they are now free, I must say, first of all, no one has had a Pap smear or mammogram. The cost is not why women don't run and line up for it. And I think that all of that, we have to get that nonsense out of there and we have to be much more direct about it.

I thank you for kicking it off with this very important issue, and I just continue to thank you for your leadership and saying women are people too and we should be treated like real adult people and trust the medical profession to deal with these issues.

Thank you, Mr. Chairman, and thank you Members and colleagues who have worked so hard on this.

Mr. WAXMAN. Thank you very much, Mrs. Schroeder.

[The prepared statement of Mrs. Schroeder follows:]

TESTIMONY OF
REPRESENTATIVE PATRICIA SCHROEDER

HEARING: "Women's Health Under Health Care Reform"

Wednesday, January 26, 1994
Washington, D.C.

Mr. Chairman, my colleagues of the Congressional Caucus for Women's Issues and I are here today to make sure women at all stages of their lives receive comprehensive and equitable treatment under health care reform.

Women's health has its similarities to men's health, but it also has its many differences. And those differences go beyond the reproductive tract, affecting every system from cardiovascular, to urological, to psychological. That means research, treatment and insurance must respond appropriately.

Women also hold a special place in health care reform because they give birth to future generations. We know healthy women are more likely to give birth to healthy babies. So it is especially important that women receive proper care from infancy to old age, including comprehensive reproductive health services.

We know that women bear more of a health care burden than men because they must access the system earlier in their lives. Young men need only seek health care if they are injured or develop diseases. Young women must tap into it from the time their reproductive systems kick in. Men lean most heavily on the system as they get older. Women must always be cognizant of health care, whether they are healthy or not.

So, we are here on behalf of our daughters as well.

Despite all this, 16 million U.S. women had no health insurance from any source in 1990, although half of them were employed. And women are more likely to have limited access to coverage because they form the bulk of part-time and temporary

workers.

We in the Caucus have said health care reform must incorporate the following general principles. I submit a copy of them for the record:

- * It must be available to everyone, regardless of income, employment status, pre-existing conditions or eligibility for other forms of public assistance.
- * It must feature a basic benefits package that includes preventive, diagnostic and treatment services for women.
- * It must give women access to full information about their treatment options and alternatives to treatment.
- * Services must be widely available.
- * Care must be free of gender stereotyping.
- * Primary care services must be community-based, accessible and coordinated.
- * Care must be based on gender-appropriate research.
- * It must include research on promoting health and preventing disease in women.
- * It must feature a standard benefits package that has comprehensive reproductive health services, including abortion, thus ensuring equal access to care.

Whatever health care policy we end up with must knock down the barriers that keep so many women, children and teens from receiving care. Among those barriers are financial hardship, lack of health insurance, unfriendly and demeaning services, inaccessible clinics with overworked staff, a critical shortage of private, primary care providers, lack of confidentiality, a crumbling public health system and bureaucratic hassles.

Health care is especially crucial for women of childbearing age. Yet more than 8.6 million of these women went without health insurance in our country in 1991, although more than 6.2 million of them were employed. In my own state of Colorado, that number translated to more than 105,000 women of childbearing age who lacked insurance, despite the fact 81,600 of them were employed.

Even among the insured, preventive services such as pre-natal care are often left out of traditional employer-based plans.

Moreover, as some women have found out the hard way, their pregnancy can be considered a pre-existing condition that results in denial of coverage.

This all adds up to an expensive proposition -- in human and monetary terms. The nation spends \$2.4 billion on uncompensated care and government payments to offset these costs, mainly for deliveries and for care of sick newborns. Difficult births and unhealthy babies cost employers and employees \$5.6 billion in 1990.

It's important that health care reform redirects some of these resources to pre-natal and other preventive services, as well as extends coverage to all pregnant women and infants, women of childbearing age and children.

Mr. Chairman, not only do we not meet the health needs of millions of women, but we leave nearly 12 million children and teens without health insurance and millions more without adequate coverage.

Seven million children do not receive routine medical care, and many of them are inadequately immunized against childhood diseases.

Only one in five children who needs mental health treatment, and less than one in eight adolescents who needs alcohol or other drug abuse treatment, receives it.

One in five teens has a health problem so serious it could interfere with normal development.

Children and youth with disabilities and their families face even greater hardships.

Any proposal for reforming health care must meet the needs of our children and our adolescents, who face increasing incidences of violence, AIDS and other sexually transmitted diseases, drug and alcohol addiction, poverty, mental illness, disabilities and other problems.

And that reform must not reduce teen "health" issues to teen "sex" issues because that will prevent us from developing a good adolescent health policy.

Care must be affordable, accessible and specific to adolescents' unique physical and psychological needs.

And care for adolescents must be confidential, so they will use the services they need. We know adolescents aged 10 to 18 are less likely to use private, office-based primary care physicians than any other age group.

That confidentiality must also be explicitly assured for everyone, not just teens. It must be left to patients to decide whether or not they will divulge information about their private medical services, whether those be for contraception, substance abuse, counseling for battered wives or other sensitive areas.

Mr. Chairman, universal coverage is the bottom-line requirement for President Clinton and the Caucus when it comes to health care reform. And because women form the bulk of the poor, many of whom are uninsured and receive subsidized health services, reform must guarantee co-payments and deductibles don't

constitute barriers to universal care.

The president's proposal is to be commended for including preventive services, such as cancer screening and family planning, in the standard benefits package available to all Americans.

His proposal is also to be commended for including coverage of services to pregnant women, which include pre-natal care, childbirth, post-natal care and abortion.

The President's legislation allows some flexibility on the frequency of mammograms, but with the current confusion in this area, we would prefer the plan explicitly assure coverage of mammograms when recommended by a health professional.

We would also like to see the President's plan adjusted to maintain health education as part of the comprehensive benefit package and to include smoking cessation as a required service offered to pregnant women in all health plans. We know smoking accounts for at least 54,000 low birthweight babies in this country annually.

The Caucus has renewed its call to the President and Mrs. Clinton for leadership on coverage of abortion. The President has made clear his intent to make abortion safe, legal, rare and covered under the standard benefits package, while allowing doctors and hospitals to opt out of providing them under a conscience clause.

It is essential to public health and women's liberty that abortion and all reproductive health services be part of health care reform.

Mr. Chairman, this subcommittee will play a key role in crafting health care reform. We trust it will keep women's issues at the forefront. We in the Caucus pledge to work with the subcommittee in every way possible to make sure women at all ages receive comprehensive and equitable treatment.



Congressional Caucus for Women's Issues

Statement of Women's Health Principles

- 1) Health care coverage should be available to all, regardless of income, employment status, pre-existing conditions, or eligibility for other forms of public assistance.
- 2) Any basic health benefits package must include important preventive, diagnostic, and treatment services for women. Such services include (but are not limited to): prenatal care and delivery services, mammography and pap smears, family planning services, and substance abuse services. Well-baby and well-child services (through adolescence) should also be included. Where appropriate, outreach and follow-up services should be available.
- 3) Women must have access to full information, including referrals, about all treatment options and alternatives to treatment in order to make informed choices.
- 4) Health care services should be available in a wide range of settings, including (but not limited to): outpatient settings, the home, hospice facilities and long-term care settings.
- 5) Services should be available through a wide variety of providers, including physicians, nurse practitioners, nurse midwives, and physician assistants. Training programs should encourage more women providers at all levels of health care.
- 6) Services should be based on individualized care appropriate to each patient. Public and provider education should be available to eliminate gender stereotyping which results in inappropriate or missed diagnoses of illness in women.
- 7) Primary care services should be community-based. Where appropriate, support services such as transportation, language translation and caregiving arrangements should be available to assure access. Wherever possible, pediatric and maternal care services should be coordinated.
- 8) Health care reform should include research on the best way of promoting health and preventing disease in women, including data on health and illness in women, service delivery modes best suited to meeting women's health care needs, health consequences of women's social and economic roles.

Mr. WAXMAN. Ms. Snowe?

**STATEMENT OF HON. OLYMPIA SNOWE, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MAINE**

Ms. SNOWE. Thank you, Mr. Chairman, and I certainly want to express my appreciation to all of you and to you in particular for holding this hearing today on women's health issues as it relates to health care reform, and I am pleased to be able to join my colleagues on behalf of the Congressional Women's Caucus to address this issue.

I don't think there are any doubts about the necessity to address the unique health concerns of women in this country. Women represent 52 percent of the population. Seventy-five percent of the medical labor force is represented by women, and despite this statistical show of force, women are first to bear the burdens in fulfilling the role of medical care givers and they are last to bear the fruits of medical research and health care treatment.

Despite the fact that women happen to be the majority of the population, I happen to believe that there is a health care gender gap in this country that is stubbornly wide despite the accomplishments that we have made over recent years. So I think that health care reform affords us the unique opportunity to address these issues in all respects, particularly as they relate to women when it comes to primary care, reproductive health care services, including abortion, and the issues related to childbearing and to pregnancy. And also long-term care. I think those are definitely the areas about which we should be concerned on the issues regarding women.

I will not go over the history of the caucus in terms of what we have tried to do. I think you are familiar with that, Mr. Chairman, and without your exemplary leadership and long-standing commitment to these issues we would not have achieved the successes that we have thus far. But I do want to reiterate certain points.

Pat made reference to the women's health care principles we think are critically important to be incorporated into health care reform. We submitted those to Mrs. Clinton on numerous occasions in which we had meetings because they do identify the areas that are important to women. We also introduced legislation last year, and in previous years, that incorporates 32 different bills on the issues relating to the health care needs of women in this country and they address research, prevention, education, and the delivery of health care services.

We believe that we ought to broaden the realm of health care for women in this country. We want to level the playing field with respect to prevention and research and medical testing in clinical study trials in this country, all of which have a direct impact on women's lives.

But when it comes to health care reform proposals, and obviously there are a number of proposals that have been introduced in the Congress, and I know Mr. Cooper referred to his, and we obviously have the President's, let us look at certain facts.

First of all, the Commonwealth Fund will testify later, but one of the statistics that they have discovered in their survey is that

women are traditionally vulnerable because of their economic status and therefore do not have health insurance.

The fact is only 37 percent of the women in this country get their health insurance through employers, whereas 56 percent of men in this country receive their health insurance through employers.

The fact is women need a broad range of health care services, as I said earlier, options that include primary care, reproductive health care, and long-term health services. Reproductive health care is absolutely crucial to women because that may be the only occasion upon which they receive routine medical services. This means that women have to have access to preventive, diagnostic and treatment services, including family planning services, pregnancy-related, care primenopausal care.

The Commonwealth survey found that one-third of women were at risk for conditions that would have been detected had they been able to have routine medical checkups. All women need appropriate screening, evaluation, as well as education, and that includes Pap smears and cervical examinations.

Now, in the President's plan, the President offers a complicated schedule for these routine exams for Pap smears, for example, depending on age, depending on risk, and depending on the routine, and I think, frankly, that whatever standards we set in the standard benefits package, that we have to make sure that the standards as they apply to women in these preventive health care measures are consistent with professional organizations and the American Cancer Society. We should ask no less of women in this country and so they should be consistent standards.

Mammographies, the President again recommends mammographies every 2 years for women over the age of 50. I think again we should adopt standards that are consistent with the American Cancer Society.

Might I also add, Mr. Chairman and Members, I was really dismayed as well as chagrined when the National Cancer Institute recently issued a statement saying that they will no longer issue guidelines for mammographies for women under the age of 50 and during their forties. I think that is unacceptable and I think it is a cop-out. That is the last thing we should be doing in this country, is sending a mixed message to women about mammographies. I guess it epitomizes the problems that women have been facing with respect to the health care debate; we are always getting the mixed messages.

But what we are now saying is, we will leave it up to the women to decide customized care, individualized choices as to whether or not they should have any mammographies during the age of 40, during the decade of the forties when, in fact, 1 in 5 women are diagnosed with breast cancer during their forties. And so I would hope that we would not accept that as a benchmark or a measurement for women in this country.

So, Mr. Chairman, those are some of the critical issues I think we should address. In addition, I do think we ought to include a component for long-term care. I think the President made an excellent start on the home health care provisions, but I think we also have to make sure the institutional settings are provided for in some fashion, at least beginning that debate and that support, be-

cause women ultimately are the ones who are in the nursing homes. Seventy-five percent of the two million residents in nursing homes today happen to be women. So I would hope that we can meet the needs and expectations of women in this country, and I know with your help and support that we can do that with whatever plan that ultimately emerges. We want to work with you and everybody that is involved in this debate. Thank you.

Mr. WAXMAN. Thank you very much, Ms. Snowe.

TESTIMONY OF OLYMPIA J. SNOWE
Subcommittee on Health and the Environment
Committee on Energy and Commerce
January 26, 1994

Mr. Chairman, thank you for the opportunity to address the Health and Environment Subcommittee about the historic opportunity we here in Congress have to reshape and improve the health care system for our citizens.

On behalf of the women of this nation, the Congressional Caucus for Women's Issues, and the members of the panels testifying today, I am pleased that you are holding this hearing on the health care needs of our country's women. I look forward to working with you to ensure that the unique health care needs of women are included in any basic benefits package that is considered by the House this year.

Women make up 52 percent of this country's population, and more than 75 percent of the personnel in America's health care labor force. Despite this statistical show of force, historically women have been the first to bear the burdens of fulfilling the role of primary medical caregivers, but the last to bear the fruits of medical research and progress in health care treatment.

Although, women do make up a majority of the population,

there remains to this day what I refer to as a "health care gender gap" - a gap that has remained stubbornly wide despite the advances we have made recently. We have a chance in 1994, as we develop health care reform legislation, to finally recognize the unique health concerns of women -- such as breast cancer and reproductive tract cancers, as well as those concerns related to family planning, pregnancy and childbearing.

As you know, Mr. Chairman, the Congressional Caucus for Women's Issues has long been involved in the fight to secure equity for women in the realm of health care. We have introduced legislation in Congress like the Women's Health Equity Act, sections of which were included in the NIH Revitalization Act and the Preventive Health Amendments, which were incorporated in the Breast and Cervical Cancer Mortality Prevention Act. Legislation spearheaded by the Caucus helped establish an Office of Research on Women's Health at NIH, and we pushed for the NIH to develop a longterm study to examine how diseases affect the unique physiology of women in the United States. Through working with you, Mr. Chairman, we know of and appreciate your longstanding commitment to women's health.

Last year, the Caucus, working with the Campaign for Women's Health, adopted a document on health care known as the "Women's Health Principles" - guidelines we believe must be incorporated into any health care reform proposal considered by Congress. I

would like to submit these for the record. I would also like to point out the we have given a copy of these principles to the First Lady and Chair of the Task Force on Health Care Reform - Hillary Rodham Clinton - and I am happy to say we have had several opportunities in the past year to meet with her and share our thoughts about this important process.

Most recently, the Caucus introduced a package of 32 bills called the Women's Health Equity Act - a package of bills designed to promote a broad health equity agenda for women. This landmark legislation is designed to give increased impetus to women's health in the areas of research, education, prevention, treatment, and the delivery of services.

The Caucus will continue to work on reaching parity for women in medical testing, clinical trials, and health research. But clearly our priority in this session will be health care reform.

The results of a recent study commissioned by the Commonwealth Fund indicate that many women do not receive necessary health care due to a lack of adequate health insurance and their vulnerable economic status. Remarkably, only 37 percent of women versus 56 percent of men have employment-based health care coverage. Coverage as a spouse poses problems because of job layoffs, insurance cutbacks and family problems,

such as domestic violence.

Simply put, Mr. Chairman, women want and deserve health care that responds to their specific needs. Women need a full range of health care options - options which include primary care, reproductive health care and long-term health services.

Reproductive health care is crucial to women because it is frequently the only regular health care they receive. This means women need access to preventive, diagnostic and treatment services including family planning services, pregnancy related care and peri-menopausal care. The Commonwealth Fund survey found that more than one-third of the women were at risk for conditions that could be detected by routine preventive care services.

In a July 17, 1993 letter to Hillary Rodham Clinton, the Caucus insisted that family planning services and women's reproductive health should be fully covered under the Administration's - or any other - plan considered by Congress.

All women need appropriate screening services that provide evaluation and education. Pap smears and pelvic exams are necessary components of women's reproductive health care. The President's plan provides a complicated schedule that varies with age for preventive services that mixes risk factors with routine

screening. It is inconsistent with recommendations of various professional groups. This proposal makes an assumption that women routinely visit a health care provider, yet recent studies contradict this assumption. I believe we do a disservice to all women if we do not provide a benefits package that allows them to make a decision on the need for screening with their health care provider.

Because of recent disagreement on guidelines for mammography to detect breast cancer, the National Cancer Institute has decided that they will not issue any further guidelines or recommendations for mammographies until further study. This has led to a great deal of concern on what constitutes appropriate and adequate screening. Mr. Chairman, we can dispel this concern by adopting a basic benefits package that grants health care providers the flexibility to do what is best for the individual, based on their specific situation. At the very least, I believe we should go along with the recommendations of the American Cancer Society.

In a September 23rd letter to the President, I joined other members of the Caucus in expressing concern about the Administration proposals' limitations on coverage for mammograms, pelvic examinations, and especially pap smears.

There are a number of health care reform proposals before

Congress, and the Caucus will continue to exhort the authors of these bills to include the aforementioned services in their proposals.

Aside from these services that should be guaranteed to every woman, Congress must pay special attention to the particular needs of America's older women.

Osteoporosis is one disease which is unique to older women across the nation - a disease which strikes older women harshly. Over half of all women over age 45, and a startling 90 percent of all women over the age of 75 are afflicted with osteoporosis. Osteoporosis is a leading cause of nursing home admissions and bone fractures for elder women. Because of the bleak reality of osteoporosis, I strongly believe that screening for diseases, such as osteoporosis should be included in a basic benefits package. Early detection can make a difference in the quality of life for someone with osteoporosis and as well as a difference in the cost of care for this disease.

We cannot afford to overlook long-term care. Forty-three percent of all Americans who turn 65 this year will eventually enter a nursing home and 25 percent of that group will stay at least one year, at an average cost of \$30,000 to \$40,000.

Providing adequate long-term care benefits means that we

need a good home-health care system for those who need some help but do not require round the clock care. We need respite care so those families who are struggling to keep a loved one at home can have a short break and some time to themselves.

And perhaps, most importantly, we need a long-term health care system that ensures access to the quality of care provided in a nursing home when it is appropriate. The latter issue is of particular relevance to women when you consider that 75 percent of the estimated 2 million nursing home residents in this country are women!

Long-term care is an issue that cannot be avoided and must not be ignored as we work together on reforming our health care system.

Another area that cannot be ignored, and if you have been hearing the same things at your town meetings as I have, it will not be, is prescription drug coverage. In the past month at town meetings across the 2nd District of Maine, this issue has dominated the discussion. And it is no wonder when you consider that prescription drug costs are the highest out-of-pocket medical cost for 3 of 4 older Americans. It has been estimated that women over age 65 spend more than \$6.5 billion on prescription drugs.

Mr. Chairman and members of the Committee, we have a unique opportunity in the process of health care reform to not only bridge the health care gender gap for women, but close that gap. If essential services such as comprehensive reproductive health care and osteoporosis screening are not part of a basic package of health benefits for women, Congress and the Administration would be sending a clear, stark, yet unmistakable message to the women of America: You are second-class citizens when it comes to health care.

I very much look forward to working with you and other Members to craft a health care reform proposal which will meet the needs and expectations of all Americans. With your help and support, I know we will. Thank you.

Mr. WAXMAN. Ms. Slaughter.

STATEMENT OF HON. LOUISE SLAUGHTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Ms. SLAUGHTER. Thank you, Mr. Chairman, and I echo, of course, what all my colleagues said about your wonderful leadership in this area. We all owe a great debt to you and the other Members.

As the chair of the women's task force on women's health, I will assure everybody we will keep a close look at this debate as it goes forth. I am pleased to say H.R. 3600 addresses some of the inequities in the health system that affect American women but a few problems persist with the legislation as written and I want to discuss those.

The best news for women, if the legislation is enacted, is the universal health coverage aspect. That means that the working women, the Medicaid AFDC mothers, and all the women among the 37 million uninsured will have access to primary health care providers who can monitor the health and provide the preventive care on a scale that we have never before seen.

The preventive screening measures contained in the Health Security Act's basic benefits package represent a great leap forward for women's health. All women will have access to important screening tests for certain types of reproductive disorders, for cancer, and other health threats, but, still, we are concerned with the legislation as written.

For example, the guideline for the coverage of Pap smear tests ought to be broader. The plan calls for an annual Pap smear for women at risk for, quote, "fertility-related infectious illnesses", unquote. This means some sexually transmitted diseases, known as STD's. However, there are numerous other STD's that are not related to fertility but are equally dangerous. Screenings, and not just Pap smears but all forms of screenings, should be covered for all STD's whether or not they lead to fertility-related disorders.

One example is the human papilloma virus known as HPV. HPV is a common sexually transmitted disease that does not affect fertility. It is, however, one of the leading causes of cervical cancer in women and is undetectable without a Pap smear and must be covered. In fact, women at risk for HPV need to be screened more frequently than once a year, and medical experts recommend a screening interval of once every 6 months.

The Health Security Act's basic benefits package should cover screening for all STD's, for both men and women, whenever it is deemed medically appropriate. The cost of failing to do early screening tests for the diseases will be much greater than the cost of covering them. A Pap smear costs only \$15, for example. I, therefore, recommend the committee consider making the guidelines for the Pap smears broader and more consistent across-the-board to save money and lives.

With regard to coverage of screening mammography, I am pleased that the benefits package does include regular screening of mammograms for women over age 50, because, indeed, it has taken us many, many, many years to just get Medicare coverage of mammograms for older women. The National Cancer Institute recently announced that mammography screening reduces the mortality

rate in women over 50 by 30 percent, but I don't believe, however, nor do my colleagues, that the age 50 and above cutoff should represent anything more than the bare minimum coverage offered.

We know so little about the causes and the risk factors involved in breast cancer. For this reason, health plans should be encouraged through legislative language to cover additional medically appropriate mammograms. Flexibility should be added to the legislation to allow women and their health care providers to determine when a mammogram is medically appropriate. We believe they are attempting to do that and we want to make sure it stays that way.

Now, while mammography is certainly not the surefire breast cancer detection that we desperately need, it is currently all we have. Much more research is needed. We need a large U.S. study of the effectiveness of the newest technology. We need research and development of a noninvasive and accurate method of detection, such as a blood test for breast cancer, or the gene that may predispose women to breast cancer. Now, we do not have any of these things, and that is why we must be extremely cautious in our talk of cutbacks on procedures.

We must be more sensitive to the fact that women in this country, understanding that their health needs have been ignored and overlooked, believe that this debate simply concerns whether or not they are worth covering, as far as the cost is concerned. Women in this country know that 46,000 of them this year, and 300 men, because of the rate of breast cancer in men is growing fairly rapidly, face death from breast cancer each year. We would not want to do anything to cause that to increase or increase the fear in women.

Historically, our health care system has failed the American women in far too many ways. By failing to guarantee equity in the research levels, our current system has left the death toll to rise year after year and decade after decade. Until we ensure the coverage for a full range of primary and preventive reproductive health care, including abortion, our current health care system can do nothing to reduce the appalling high rates of teenage pregnancy, infant mortality, babies born drug addicted, infected with HIV, or with fetal alcohol syndrome. Each of these problems place costly burdens on the parents and health care systems, our schools, our housing programs, our criminal justice system, and the entire national economy.

In closing, I would like to reemphasize that this year we have an opportunity to make a dramatic improvement in the health status of the United States' population, including the majority of that population, the 51 percent who are women. In the past years, certainly while I have been here in Congress, the Congress and the previous administrations have been enormously successful in controlling the rights and choices and lives of poor women, even though our fights have gotten better and closer.

I would also like to say to all the Members of Congress and the administration and anyone else that the right to choice for every man and woman in the United States who believes it is a right that they pay for, a right that they have guaranteed by the Constitution, a right of choice, should not be taken away lightly by any of our colleagues in Congress. And I urge them to think about it very closely.

But let me add just one other very small point and that is if we are going to choose what we will cover and what we want, my choice is going to concentrate on covering the diseases caused by smoking. Four hundred sixty thousand Americans die every year. The health costs are enormous and, frankly, if we are going to have the choice to go back to the old complaints that were always used on women, they got themselves in trouble so let's think about whether we will cover that, if we are going to decide that women are not worth coverage in this country.

And I thank you very much for your kind attention and look forward to working with you in the future on this issue.

Mr. WAXMAN. Thank you very much, Ms. Slaughter.

Mrs. Lowey.

STATEMENT OF HON. NITA LOWEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mrs. LOWEY. Thank you, Mr. Chairman. I want to join my colleagues in commending you for calling this hearing and for your leadership. I don't think it is coincidental that you are doing this the first week of the congressional session. It is a very strong signal to American women that we will be a priority in the health care system of the future.

This committee, with your leadership, has taken the lead on a number of health care issues, and we are very, very grateful. In particular, you have truly been instrumental in any progress that has been made in family planning and reproductive rights, and we are very grateful. Therefore, I am confident that we can count on you and this committee to ensure that reproductive health care is given the priority and coverage that American women need and deserve.

In these areas, the President's package, as submitted to the Congress, earns high marks. It recognizes the fact that family planning and contraceptive services have not historically had the kind of coverage that makes sense and the plan would provide that coverage. It respects the need for making available a full range of reproductive health services, and by maintaining the coverage that is widely provided by private insurers today, reinforces the right to choose safe, legal abortion. In this regard, the Health Security Act represents a major step toward correcting historic inequities in our health care system.

Today, 14 million American women of reproductive age are uninsured. The consequences of that tragic statistic are seen in higher infant mortality rates, low birth weight infants, and pregnancy-related complications. We must respond.

Later today you will hear the results of a study by The Women's Research and Education Institute and the Institute for Women's Policy Research, which shows that women bear a disproportionate share of out-of-pocket costs for their reproductive health care. That is largely due to the fact that even those plans which do cover family planning services do so with high deductibles and copayments. We cannot allow that situation to continue.

As those of you on the subcommittee know, family planning services are among the most cost-effective services we can provide. They are crucial to reducing unintended pregnancies, to avoiding

pregnancy-related complications, and to improving maternal and child health generally.

Studies have shown that the Federal Title X family planning program saves \$4 in health and welfare costs for every public dollar invested. And last year that meant \$1.8 billion in savings, and that figure could readily be multiplied several times over as the services become available to the millions of women who lack them today. The Health Security Act would for the first time extend insurance coverage to all women for these services, which makes sense both for our families and for the Nation.

We do have two specific suggestions for improving family planning and contraceptive coverage. First, the committee should treat family planning services as preventive services, so that they would not be subject to copayments and deductibles. This not only makes sense, because these services are clearly preventive in nature, but also because this would encourage a greater use of these services, thereby reducing the overall cost of our health care system.

Second, contraceptive drugs should be explicitly covered under the plan. They are essential to ensuring access to the full range of effective planning options and their status should not be left to chance.

I cannot stress strongly enough the importance that American women attach to having access to the full range of reproductive health care services. There are those who will attempt to turn the health care reform process into a political debate over abortion and to use this as an opportunity to restrict a woman's right to choose. That must not be allowed to occur.

Basic health care should not be determined by a poll. After all, Mr. Chairman, the Health Security Act simply maintains the status quo with regard to abortion coverage. Today, the majority of health care plans, Blue Cross/Blue Shield, Aetna, Travelers, Kaiser Permanente and many others cover abortions as a matter of course. In light of that, failure to cover these procedures under health care reform would be a loss of coverage for millions of American women.

The administration's plan has its priorities right. It will give women the means to improve their health and make real choices. This plan recognizes that the abortion option is basic to women's health and must be covered. The whole debate is about expanding access to affordable health care services, and women who have been the most neglected in our health care system historically expect that standard to apply to us as well.

Absence of abortion coverage in a national plan would marginalize this basic procedure and rendering the legal right to choose meaningless for many American women. It would relegate this legal service once again to the back alley and put women's lives at risk.

Again, Mr. Chairman, when it comes to reproductive health care services, the administration has put forward a package that recognizes the common sense of providing coverage for the full range of reproductive health care services. Their plan also keeps faith with American women by ensuring that the legal right to choose is not destroyed by lack of access.

The women of America and the members of the House Women's Caucus see health care reform as an unprecedented opportunity to

correct historic inequities, and broad coverage of reproductive health services is an essential component of any plan that can truly claim to have addressed the needs of all Americans. Coverage of the full range of reproductive services, including abortion, is absolutely essential to securing broad based support from members of the Women's Caucus for the plan. We will not support a package that takes women backwards.

Thank you again for your support, for your attention, and for your leadership.

Mr. WAXMAN. Thank you very much, Ms. Lowey, and all four of you and members of the Congressional Women's Caucus for your presentation to us. I think what you have had to say to us is something that we very much have to keep in mind as we look at this health care reform package.

I have no questions for you. I know you have other appointments to keep. I will see if any Members have anything they want to ask, otherwise we do have a long list of witnesses waiting.

Mr. Klug.

Mr. KLUG. Just a comment, Mr. Chairman, to Mrs. Schroeder, and some other people who raised a question.

As one of the people who has been involved early on with the Cooper bill, I think it is clear that in just about every health care bill being considered there are disagreements among members of any coalition, including the Cooper bill as well. There are a number of us who are pro-choice who want to make sure women who currently have health care benefits don't find themselves in the future without abortion services.

Mrs. SCHROEDER. Thank you. That is wonderful to hear.

Mr. WAXMAN. Thank you. We look forward to working with you on this issue.

Our next panel is made up of our colleagues who are representing the Congressional Pro-Life Caucus. They are Representative Henry Hyde; Barbara Vucanovich; and Representative Christopher Smith.

We are pleased to welcome you to our hearing today. Your prepared statements will be in the record in full. We would like to ask you, if you would, to limit the oral presentation to 5 minutes.

Mr. Hyde, why don't we start with you. There is a button on the base of the mike. Be sure to push it forward.

STATEMENT OF HON. HENRY J. HYDE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. HYDE. Thank you very much, Mr. Chairman. I surveyed the room and I feel like Indiana Jones in the Temple of Doom, but, nonetheless, except for Mr. Bliley. I do thank you, though, for the opportunity to testify on behalf of the House Pro-Life Caucus, and it should come as no surprise that I stand in strong opposition to those provisions of President Clinton's bill that would place the full power of the Federal Government behind the promotion of abortion as a routine health benefit and force all Americans to pay for abortion on demand.

The President has included abortion as a part of his basic benefits package under the description of family planning and pregnancy-related services. We are told that abortion should be covered

because it is no different than any other medical procedure. On the contrary, it is completely different. In *Harris v. McRae*, the Supreme Court stated that, "Abortion", and I quote, "is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." In my humble judgment, the court is wrong only in the fact that an unborn child is not a potential life, it is a human life with potential.

But, Mr. Chairman, I have been involved in debates over abortion policy in this body since 1975, and as Ranking Republican Member on the Judiciary Committee's Subcommittee on Civil and Constitutional Rights, I have participated in many hearings and markups on abortion-related legislation, including most recently the so-called "Freedom of Choice Act", a bill intended to nullify most remaining State limitations on abortion. And based on this experience, I can say that President Clinton's health care bill contains the most extreme pro-abortion provisions of any legislation ever introduced in Congress, even more extreme than the Freedom of Choice Act.

Now, this bill represents an attempt to impose on the entire population by force of law the ideological position of a small minority; namely, that abortion must be treated as indistinguishable from any routine medical procedure. The bill would force everyone to directly support a procedure that many millions of Americans find morally offensive, since it takes the life of a defenseless living member of the human family. They will be coerced to support it through government-mandated premiums, deducted from their paychecks, and through their Federal taxes as well.

However, the majority of Americans do not want abortion included in any national health care plan. For example, consider polls conducted by The New York Times in March and June of last year which asked specifically whether abortion should be included in the basic benefits package. These polls found American women overwhelmingly opposed to including abortion—72 percent in the March poll and 65 percent in the June poll. Clearly, the majority of American women do not want abortion as a mandated benefit in health care reform.

In November 1992, a Wirthlin poll asked, quote, "Do you favor or oppose abortion being allowed as a method of birth control?" Eighty-four percent of Americans and 89 percent of American women said that abortion should not be, quote, "allowed", close quote, as a method of birth control. Yet the Clinton plan allows abortions for any reason whatsoever, equating undergoing an abortion with an appendectomy.

I urge members of the subcommittee to keep these poll results in mind the next time they are told that it is offensive to women for a government-run health program to treat abortion differently from birth control devices, vasectomies and mastectomies.

When I hear people say, speaking for American women, with great respect and deference, that is awfully presumptuous. There are millions of American women that find abortion morally repulsive. Not arguing the merits of abortion, I am saying the fact is there are millions of people out there who abhor abortion and I am speaking on behalf of them. Not all women, not all pro-lifers, but the facts are there are millions of people that despise abortion.

Now, including abortion in a federally mandated benefits package has far-reaching ramifications. Contrary to the President's statements last September, Americans would not have the option of joining plans that do not pay for abortions—I see my time is nearly up. Let me just hurry through this, if I may. I won't tally—An individual doctor or an individual hospital can refuse to perform abortions under the conscience clause but the health plan itself must enter into a contract with a local abortion provider and must pay for all abortions.

Every employer would be forced to contribute to coverage for abortion on demand for all employees. No health plan could be sold if it did not provide access to abortion within the local area covered by the plan. This requirement means that the Federal Government, through the regional health alliances, would mandate the creation of large numbers of abortion mills and providers in communities where right now none exist.

Beginning in about the middle of 1993, pro-abortion advocacy groups began to assert, and I heard it here this morning, that most American women already have insurance that covers abortion. Failure to mandate abortion would take away a very important benefit.

There is no data to support that statement. In fact, there is contrary evidence. The St. Louis Post-Dispatch reported last September that, quote, "A spokesman for A. Foster Higgins, Inc., a national employee benefits consultant that surveys 2,500 employers a year, said such coverage was common in HMO's but unusual in fee-for-service plans and in employers' self-funded plans."

I have much evidence here to show that is not routinely available right now. Most insurances do not provide it. It is available, but it is not provided.

To cut to the chase, Mr. Chairman, I am simply saying this is a whole plan that is controversial. We want to do something about reforming the terrible gaps that we all can see exist in health care. We want to support something. But to force feed the payment for abortions on millions of people who have the strongest moral scruples against it is not only wrong but it could sink this whole program. I don't want that to happen, and I simply suggest to you that we take abortion out of the mandate and let people who want that coverage buy it privately, privatize that, but to put that albatross around this program, I think is a serious mistake, and I thank you for your courtesy.

Mr. WAXMAN. Thank you very much, Mr. Hyde.

[The prepared statement of Mr. Hyde follows:]

Abortion Mandates in the Clinton Health Bill

Testimony of Congressman Henry J. Hyde

Before the Subcommittee on Health and the Environment,

House Committee on Energy and Commerce

January 26, 1994

Mr. Chairman, I thank you for this opportunity to testify on my own behalf and, with my colleagues, on behalf of the House Pro-Life Caucus.

We testify in strong opposition to those provisions of President Clinton's bill that would place the full power of the federal government behind the promotion of abortion as a routine health benefit-- and force all Americans to pay for abortion on demand.

Mr. Chairman, I have been extensively involved in the debates over abortion policy in this body since 1975, and before that as a member of the Illinois legislature. As the ranking Republican member of the Judiciary Committee's Subcommittee on Civil and Constitutional Rights, I have participated in innumerable hearings and markups on abortion-related legislation, including most recently the so-called "Freedom of Choice Act," a bill to nullify most remaining state limitations on abortion. Based on

this experience, I can say, without exaggeration, that President Clinton's health care bill contains the most extreme pro-abortion provisions of any legislation ever introduced in Congress-- even more extreme than the Freedom of Choice Act.

This bill represents an attempt to impose on the entire population, by force of law, the ideological position of a small minority-- namely, that abortion must be treated as indistinguishable from any routine medical procedure. The bill would force everyone to directly support a procedure that many millions of Americans recognize takes the life of a living member of the human family-- support it through government-mandated "premiums" deducted from their paychecks, and through their federal taxes as well.

In seeking to hijack health care reform for this purpose, pro-abortion advocacy groups demonstrate that the term "pro-choice" is indeed a misnomer. They seek to use the full weight of law to compel every American to acquiesce in and participate in their vision of abortion as a morally neutral act-- or rather, as a positive good, a "basic benefit."

In August and September, before the bill was formally introduced, the President, the First Lady, and various Administration officials made a number of public statements that very substantially understated the requirements of this bill with respect to abortion. These statements confused the public-- but now, as the truth is becoming more widely understood, I believe that many Members of Congress will perceive more clearly during the weeks and months ahead the growing breadth and intensity of the opposition that these provisions are engendering towards the President's proposal.

Funding of Abortions

My testimony today centers only on the pro-abortion ramifications of the President's bill. I personally have a number of major problems with the President's bill, including the manner in which I perceive that it would quickly lead to widespread rationing of vital health care. I hope to see those other problems corrected, but even if they are, I would strongly resist any legislation that would grant the federal government expanded powers to promote abortion and tax funding of abortion.

I also note that there are many other pro-life Members of the House who are more favorably disposed than I towards greatly expanding the

federal government's role in managing health care delivery. But for every genuinely pro-life Member of the House, and even for many who have what might be considered "middle" positions on abortion policy, the President has created an enormous problem by proposing to include abortion as a federally mandated health benefit.

Keep in mind that last June, the House voted 256 to 171 in favor of the amendment that I offered to the Health and Human Services appropriations bill, to prohibit federal Medicaid funding of abortions, except in three rare circumstances. If you look at that roll call, Mr. Chairman, you will find well represented, among those 256 House members who voted against government funding of abortion, virtually every faction in the health care debate. Ninety-nine Democrats voted for the Hyde Amendment, while only 16 Republicans voted against it.

Yet, the President's bill would provide tax-subsidized coverage of abortion on demand for the entire Medicaid population, thereby nullifying the federal Hyde Amendment and the restrictions on tax-funded abortion in effect in 37 states. And that is just one aspect of the sweeping abortion mandate woven into the President's bill.

The Abortion Mandates: Fact and Fiction

With regard to abortion, there is a great gulf between the *descriptions* of this bill's provisions by the President and his surrogates, and the actual provisions of the bill. I was astonished when I read the transcript of a September 23, 1993 Cable News Network broadcast in which First Lady Hillary Clinton said, and I quote, "We are not increasing the availability or decreasing the availability of abortion. We are really trying to strike a balance so that we provide what is available now."

Mr. Chairman, that was truly an breathtaking misrepresentation. I have read analyses of the President's bill by leading authorities on both sides of the abortion issue (and you will hear some of these today). Neither side's analysis is remotely consistent with Hillary Clinton's claim that this bill does not increase the availability of abortion services. In fact, *both* sides recognize that the bill would work a drastic change in abortion policy.

For example, I read a speech by Pamela Maraldo, the president of the Planned Parenthood Federation of America, in which she suggested that

putting abortion in a federally mandated benefits package would be "a watershed event just as significant, just as vital, as the Supreme Court's decision on *Roe versus Wade*." It would, she indicated, ensure "that all reproductive health care -- including abortion services -- are woven into the mainstream of health care delivery in America."

It is impossible to reconcile that statement, and many others like it by leading pro-abortion advocates, with Hillary Clinton's claim that the bill merely preserves the status quo on abortion policy.

The facts are these: the President's bill includes "family planning services and services for pregnant women" in the federally mandated "comprehensive benefits package." After some initial mumbo-jumbo by Administration officials, the President and the First Lady explicitly acknowledged last September that this terminology encompasses abortion at a woman's request-- an assessment shared by legal experts on both sides.

Including abortion in the federally mandated benefits package has far-reaching ramifications, including:

(1) No health plan could be certified for sale to the public unless covered abortion without restriction. Contrary to the President's statements last September, Americans would not have the option of joining plans that do not pay for abortions. An individual doctor or an individual hospital can refuse to perform abortions-- but the health plan itself must enter into a contract with a local abortion provider, and must pay for all abortions.

(2) No health plan could be sold if it did not provide access to abortion within the local area covered by the plan. This requirement means that the federal government, through the quasi-governmental "health alliances" established by the bill, would mandate creation of large numbers of new abortion mills in communities where none currently exist.

(3) Every employer would be forced to contribute to coverage for abortion on demand for all employees. There are no exceptions to this federal mandate. For example, you will hear later today from a representative of the Southern Baptist Convention. Under the President's bill, every Southern Baptist church and every agency of that denomination would be compelled, by force of law, to pay premiums to cover abortion on demand.

(4) With a few very limited exceptions such as undocumented aliens, every working American would have government-mandated "premiums" taken from

their paychecks to pay for abortion on demand.

(5) Direct tax revenues also would be used to pay for abortion on demand for low-income Americans-- for example, those now covered by Medicaid-- thereby nullifying the Hyde Amendment and the laws of 37 states that restrict tax funding of abortions. Women and girls currently covered by Medicaid would be brought under the guaranteed benefits package, with the government paying for their benefits-- including abortion on demand.

In a September 23 1993 "town hall meeting" in Tampa, broadcast live on ABC, Ted Koppel questioned President Clinton specifically on this point.

Ted Koppel: Are tax monies going to be used to support those abortions?

President Clinton: The answer is, indirectly they will... Under this system, people on Medicaid would be just like any other person. They'd join a health plan, they'd sign up for certain services. The funds, the public and the private funds, would all be mixed together.

Ted Koppel: ... So implicitly, the answer is yes, they will be.

President Clinton: They will be able to fund it, that's right.

(6) Defining abortion as a mandated benefit means that the "National Health Board," made up of seven presidential appointees, would have sweeping powers to nullify state laws or policies that even slightly limit access to abortion. To cite just one example, pro-abortion groups have become increasingly critical of the laws in effect in 46 states that allow only licensed physicians to perform legal abortions. The bill explicitly authorizes the Board to nullify state laws governing the qualifications of medical professionals. This would certainly lead to a federal decree legalizing performance of abortions by nurse practitioners, nurse midwives, and physician assistants-- a point cited in favor of the bill by groups such as Planned Parenthood. Other state laws that regulate abortion, such as parental consent laws, waiting periods, and so forth, could also be nullified by the National Health Board as impediments to access to a federally guaranteed benefit.

**Do Most American Women Agree That Abortion Must Be Provided
on the Same Basis as Other "Reproductive Health Services"?**

I believe that the President made a big mistake when he decided to allow his bill to be used as a vehicle by pro-abortion advocacy groups. The bill currently reflects the ideological position of those who insist that the government must promote and fund abortion as if it was completely indistinguishable from pre-natal care, or contraception devices, or other so-called "reproductive health issues."

This ideological position is held by only a small minority of the American people. National public opinion polls demonstrate that even most of those who are called "pro-choice"-- those who favor keeping abortion legal, up to a point-- firmly reject the notion that the government should treat it as simply a routine medical benefit.

You will hear testimony today to suggest that removing abortion from the government-mandate benefits package would be to discriminate against "women." Yet, these same polls show that the substantial majority of women believe that it is perfectly appropriate for the government to distinguish between abortion and other so-called "reproductive health services," by refusing to pay for abortion or to include it in a government-defined health insurance package.

For example, consider polls conducted by *The New York Times* in March and June of 1993, which asked specifically whether abortion should be included in the basic benefits package. *These polls found American women overwhelmingly opposed to including abortion-- 72% in the March poll, 65% in the June poll.* (In both polls, the differences between men and women were within the margin of error).

A large survey, conducted by the Alan Guttmacher Institute in 1987, found that half of all women seeking abortions, neither they nor their partner was using any form of fertility control during the month in which the conception occurred. The President would require us all to pay for providing abortion as a method of birth control, on precisely the same basis as birth-control devices, sterilization procedures, and so forth. Yet, most Americans-- including many who regard themselves as "pro-choice"-- reject the notion that abortion should be treated as just another method of birth control.

For example, a November 1992 Wirthlin poll asked, "Do you favor or

oppose abortion being *allowed* as a method of birth control?" [emphasis added] Eight-four percent of Americans, and 89 percent of American women, said that abortion should not be "allowed" as a method of birth control. I urge members of the subcommittee to keep this in mind the next time they are told that it is offensive to women for a government-run health program to treat abortion differently from birth-control devices, vasectomies, etc.

"Taking It Away"?

There is a related issue that I must also address. Beginning in about the middle of 1993, pro-abortion advocacy groups began to assert that most American women already have insurance that covers abortion, and that failure to mandate abortion in a federal benefits package would therefore constitute "taking away" a precious benefit. Later, the President picked up this claim.

This argument is badly flawed in several respects.

First, it is not self-evident that the government is "taking away" abortion benefits if it merely declines to mandate them. Does the Administration really want to embrace the doctrine that any limitation on scope of the federal benefits package constitutes a "taking away" of benefits that Americans are currently free to purchase on the private insurance market?

After all, those Americans who currently do have abortion insurance have it because of marketplace decisions reached by insurers and consumers of insurance. If, as we advocate, abortion is explicitly excluded from the federally mandated benefits package, those who desire such coverage-- individuals, employers, or other groups-- will remain free to purchase it on the private market, just as they are now.

Secondly: those making the claim that most American women already have abortion insurance have failed to produce any real evidence that this is the case, instead citing small and unrepresentative samples of insurers. Indeed, there is substantial and growing evidence that abortion coverage is far from commonplace in many types of private health plans. *St. Louis Post-Dispatch* reported on September 24, 1993:

A spokesman for A. Foster Higgins, Inc., a national employee benefits consultant that surveys 2,500 employers a year, said such coverage was common in health maintenance organizations but *unusual in fee-for-service plans and in employers' self-funded plans. Self-funded plans provide health coverage for 65 percent of American workers.*

Various organs of the press have found abortion insurance to be generally uncommon in various regions of the country. For example, the *Post-Dispatch* reported that "such [abortion] coverage appears to be the exception in Missouri and Illinois." B.J. Isaacson-Jones, president of Reproductive Health Services, Missouri's largest abortion clinic, told the *Post-Dispatch* that less than 10 percent of the clinic's clients have insurance for abortions. "The insurers that cover abortion are few and far between," Isaacson-Jones said.

Similar results have also been found in some other states in which media organs have gone out to check on the President's claim. For example, the *Omaha World-Herald* (Sept. 28, 1993) quoted Reisha Johnson, administrator of one of the three abortion clinics in Nebraska, as saying, "Most plans do not cover elective abortion....If we can get insurance to cover it, that would be a real boon." The *World-Herald* also reported:

Mutual of Omaha, the nation's largest provider of individual health insurance and one of the largest group health insurance providers, generally does not cover abortions...Individual and group policies that Mutual sells 'specifically exclude elective abortions'..."

Mr. Chairman, the pro-life movement will energetically oppose the President's bill or any other bill that does explicitly exclude abortion from the scope of any government-defined benefits package, whether defined by the bill itself or by an agency such as the "National Health Board."

Thank you.

A CBS / *New York Times* poll (March, 1993) asked, "Should abortion for women who want it be covered as part of a basic health care plan or should it be paid for directly by the women who want it?" The response was:

	Total	Men	Women
Should be covered:	23%	24%	22%
Should NOT be covered:	72%	72%	*72%

* Note: 72% of the women polled said abortion should NOT be covered as part of a basic health care plan.

Three months later, in June 1993, a CBS / *New York Times* poll asked the same question and yielded similar results. "Should abortion for women who want it be covered as part of a basic health care plan or should it be paid for directly by the women who want it?" The response was:

	Total	Men	Women
Should be covered:	25%	26%	25%
Should NOT be covered:	66%	66%	*65%

* Note: 65% of the women polled said abortion should NOT be covered as part of a basic health care plan.

Mr. WAXMAN. Mrs. Vucanovich.

STATEMENT OF HON. BARBARA F. VUCANOVICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEVADA

Mrs. VUCANOVICH. Thank you, Mr. Chairman, and I appreciate the opportunity to testify before your subcommittee today regarding the impact of the President's Health Security Act and other similar health care proposals.

Although I am grateful that the President's plan is bringing the issue of health care to the forefront of public disclosure, I do have a number of concerns regarding this type of legislation. For instance, the inflexibility of the standard benefits package, the rationing of life saving care, the lack of choice for the consumer, and particularly phrases like "services for pregnant women."

While services for pregnant women would provide prenatal care and family planning services, it would tragically make abortion a new Federal entitlement. This plan would force millions of tax-paying Americans to participate in the taking of innocent human lives—in fact, approximately 1.6 million lives a year.

The Roe v. Wade decision was based on the assumption that every woman has a right to privacy. As a private individual, she is able to obtain an abortion without the involvement of government or society. But a right to privacy does not imply that a woman also has a right to receive financial assistance, especially from the taxpaying American public, particularly when 72 percent of women believe that a woman should pay for her own abortion.

Under the Clinton plan, employers and employees, regardless of their own personal beliefs, would be forced to pay premiums in order to participate in plans that clearly mandate abortion coverage. Every American who pays taxes would be funding abortions. In 1976, the Federal Government was paying for more than 300,000 abortions a year before Congress wisely enacted the Hyde amendment, which prohibits abortions except to save the life of the mother, and now includes coverage for cases of rape and incest. Despite the efforts of some to remove this funding limitation, the Hyde amendment still enjoys the support of the majority of American people.

Some people claim that by providing this coverage we simply would mirror the coverage provided by private insurers. However, there is no definitive source of nationwide data regarding abortion insurance coverage. In many States, abortion coverage is the exception rather than the rule. In Nebraska, for instance, the director of one of the State's three abortion clinics was quoted as saying, quote, "Most plans do not cover elective abortions; if we could get insurers to cover abortion, it would be a real boon", unquote.

Even the Nation's largest provider of individual and group health insurance, Mutual of Omaha, specifically excludes all elective abortions from its coverage. This leaves no doubt that mandating abortion coverage would greatly expand the scope of abortion in our country.

Others here today would have you believe that abortion should be covered because it is simply another medical procedure, much like removing an unwanted tumor or wart. However, in 1980, the Supreme Court ruled abortion is inherently different from other

medical procedures because no other procedure involves the purposeful termination of potential human life.

Abortion is inherently different and controversial. A March 1993 CBS/New York Times poll found that 72 percent of Americans do not want abortion covered under a basic insurance plan. I agree. Abortion without restrictions funded by taxpayers has no place in basic health coverage.

It is perplexing that the President's plan holds up choice for government-mandated abortion coverage when they limit the choice between real health prevention and real health problems. One example is the coverage the administration includes for breast cancer screening. Breast cancer is not a state of being, as is pregnancy, but it is a dangerous disease which can kill. I know because I survived this deadly disease.

As a woman, I am insulted that the administration has decided to limit mammography coverage under the basic benefit plan to once every 2 years for women over age 50. That coverage is currently what Medicare provides and according to the National Cancer Institute and the American Cancer Society, it is not frequent enough. Do you know how large a tumor can grow in 2 years? It can kill in 2 years or less, for that matter.

What about those women who are younger than 50? Do they have choices? The Clinton administration is not offering them any screening test availability unless it is determined that it is medically necessary. What does this term mean? Does it mean when a lump is found? Does it mean when there is a family history of breast cancer? No one knows because the administration is unclear. In the meantime, the administration is proposing to change women's existing health coverage, which in many cases does offer these life-saving procedures.

When talking about women and choice, let's not get confused. The Clinton health proposal does not give women the right to choose. It limits the care they need. It limits the doctors they may wish to see, and it limits their freedom to make the decisions about their own health care. Health care reform is supposed to improve the health of our citizens, both male and female. At this point I don't see the Clinton health care proposal doing that.

Choices are never easy to make, but what lies in the balance are human lives—the lives of children, the lives of men, and the lives of women in our Nation. Let's not make a choice we and the American people will regret. We simply cannot accept the Clinton health care proposal as presented.

I thank the chairman for this opportunity to speak and urge him to seek changes which will actually help protect, preserve, and improve the lives of our citizens now and in the future.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Representative Vucanovich. Mr. Smith.

STATEMENT OF HON. CHRISTOPHER SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. SMITH. Thank you, very much, Mr. Chairman, and I thank you for this courtesy, and Mr. Bliley and members of the subcommittee.

The President's proposal to include abortion on demand as a mandate benefit is extreme, it is unethical, and completely out of the mainstream of American thought and opinion.

Rather than nurture and protect human life, the administration proposes to coerce millions of conscientious objectors into subsidizing the violent deaths of millions of unborn babies. Please, Mr. President, we want no part of this child abuse.

Mr. Chairman, the President's plan treats pregnancy as a disease or illness and unborn children like tumors, a diseased pancreas, or so much garbage who are unworthy of either respect or compassion. This, it seems to me, flies in the face of the purpose of health care reform, protecting the weak, the vulnerable, the sick and including all.

In a word, this provision is antichild and will lead to many, many more babies dying in a painful way and will subjugate their mothers to a myriad of health risks. This proposal will force every American, Mr. Chairman, every taxpayer, every employer, every working woman, every working man to be party to the chemical poisoning or dismemberment of innocent children.

Under the Clinton plan, an unborn child at any stage of gestation—fourth, fifth, sixth month and beyond—will be vulnerable to the abuse of abortion. And Mr. Clinton wants to force Americans to pay no matter how much they object. So much for choice, Mr. Chairman.

Poll after poll, as has been pointed out by my colleagues, has shown that Americans do not want abortion as a part of the basic benefits. The New York Times, which is no friend of the pro-life cause, has found over and over again that a fourth of the people say put it in there, three-fourths say take it out.

Mr. Chairman, the American people realize that pregnancy is not a disease; that babies are not throwaways, they are not chattel, they are not objects. These little kids deserve better than chemical poisoning; they deserve better than injections of saltwater; they deserve better than dismemberment by suction means and other means. These kids, like their mothers, deserve our love, our compassion, and our respect. Americans in increasing numbers know that every abortion stops a beating heart and they do not want their tax dollars being used to subsidize that kind of violent act.

Last night, Mr. Chairman, in his State of the Union Address, the President stressed the importance of strengthening families. Mr. President, members of this committee, Mr. Chairman, you do not strengthen families by destroying family members.

Interestingly enough, Mr. Clinton himself did not always see things the abortionist's way. In a September 26, 1986, letter to an Arkansas constituent, then-Governor Clinton wrote, and I quote, "I am opposed to abortion and to government funding of abortions. We should not spend State funds on abortions because so many people believe abortion is wrong."

As recently as July 16 of 1991 he told the Arkansas Gazette, and I quote, "I've also supported parental notification and restrictions on public funding for abortions..."

We hope that Mr. Clinton will reclaim those earlier convictions, because if he succeeds in enacting the plan as currently written,

millions of babies will needlessly suffer, and the legacy of this President will be that of abortion President.

Mr. Chairman and members of the committee, I would ask you and I would ask Members of the House and the Senate to focus on the methods of abortion. There is a new method, a so-called "exciting method", that guarantees children will not survive the abortion procedure, called the D&X method, recently described by an Ohio abortionist, and I quote him. And I have the full quotation for the written text.

The surgeon takes a pair of blunt curved Metzenbaum scissors in his right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull.

Reassessing proper placement, the surgeon then forces the scissors into the base of the skull. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The abortionist goes on to say the surgeon then removes the scissors and introduces a suction catheter into the hole and evacuates the skull contents. Ladies and gentlemen, the skull contents are the brains of these unborn children that are then vacuumed out.

We need to focus on these methods, I say to my colleagues, because this is the kind of abuse that will be subsidized by every taxpayer if we are not successful in changing this particular plan.

Finally, Mr. Chairman, as you well know, Mr. Clinton has said time and time again, he said it as a candidate, he has said it as well as President, that he wants to make abortions rare, yet his actions over the past year would suggest otherwise. On both the domestic and international front, the President's policies have promoted abortion on demand.

Mandating abortion as a basic benefit seems to have made even some of the President's own advisors leery. David Gergen, before he joined the President's team, wrote, and I conclude on this, apparently abortion is to be treated as a routine medical procedure easily available to all. No questions, no costs, no issues of morality or personal responsibility. This will make abortions rare, Mr. Gergen asks?

He finally says the floodgates to universal abortion on demand funded by taxpayers will be open. What we need, then, are policies that show compassion towards women as well as a high ethical regard towards unborn children. He writes in conclusion, we stand in danger of having neither.

Mr. Chairman, Mr. Gergen is right.

Mr. WAXMAN. Thank you very much, Mr. Smith.

[The prepared statement of Mr. Smith follows:]

STATEMENT OF HON. CHRISTOPHER SMITH

Mr. Chairman and members of the Subcommittee, the President's proposal to include abortion on demand as a mandated benefit in his national health insurance plan is extreme, radical, and completely out of the mainstream of American thought and opinion.

Rather than nurture and protect human life, this Administration proposes to coerce millions of conscientious objectors into subsidizing the violent deaths of millions of unborn babies. Please, Mr. President, we want no part of this child abuse!

Mr. Chairman, the President's plan treats pregnancy as a disease or illness and unborn children like tumors, a diseased pancreas, or so much garbage who is unworthy of either respect or compassion. This flies in the face of the purpose of health care reform — protecting the weak, vulnerable, the sick, and including all.

In a word, this provision is "anti-child" and will lead to many, many more babies dying in a painful way, and will subjugate their mothers to a

myriad of health risks.

This proposal will force every American – every taxpayer, every employer, every workingwoman and every workingman to be a party to the chemical poisoning or dismemberment of innocent children. Under the Clinton plan, an unborn child at any age of gestation – 4th, 5th, or 6th month of pregnancy, right up until birth – will be vulnerable to the abuse of abortion. And Mr. Clinton wants to force Americans to pay, no matter how much they object. So much for choice.

Poll after poll, Mr. Chairman, has found that Americans do not want abortion as a basic "benefit". A CBS/New York Times poll conducted last March found that only 23% of Americans want abortion to be covered as part of a basic health care plan. That is 72% of Americans who say "get it out of there!" This clearly indicates that the inclusion of abortion in national health coverage is out of the mainstream. It is expensive and actually jeopardizes the passage of a health care reform package.

Mr. Chairman, the American people realize that pregnancy is not a

disease, that babies are not throwaways, they are not chattel, they are not objects. These little kids deserve better than chemical poisoning and dismemberment by either suction or other means. These kids, like their mothers — deserve our love, our compassion, and our respect. Americans know that every abortion stops a beating heart and they do not want their tax dollars being used to subsidize that kind of violent act.

Last night, in his State of the Union speech, the President stressed the importance of strengthening families. But Mr. President, you don't strengthen families by destroying family members.

Interestingly enough, Mr. Clinton did not always see things the abortionist's way. In a September 26, 1986 letter to an Arkansas constituent, then-Governor Clinton wrote, "I am opposed to abortion and to government funding of abortions. We should not spend state funds on abortions because so many people believe abortion is wrong." As recently as July 16, 1991, Mr. Clinton told the Arkansas Gazette, "I've also supported parental notification and restrictions on public funding for abortions..."

Reclaim those earlier convictions, Mr. President, because if you succeed in your current plans, millions of babies will needlessly suffer the cruelty of abortion. And your legacy in history, Mr. President, will be that of the "Abortion President".

Mr. Chairman, I would like to encourage Members to better understand exactly what the President wants to make us pay for. Consider this example: in September 1992, the National Abortion Federation conducted a seminar on late-term abortions. Dr. Martin Haskell, an Ohio abortionist, delivered a paper and presented a 10-minute video on an "exciting" new late-term abortion procedure which he calls "D&X", which stands for "dilation and extraction" -- a procedure which would be subsidized by the taxpayers if the President's health care plan is enacted in its proposed form.

Dr. Haskell describes how the surgical assistant uses an ultrasound probe to identify the "fetal lower extremities" [legs]. "The surgeon then applies firm traction to the instrument...and pulls the extremity into the vagina," Dr. Haskell explains.

He then goes on to describe the 'procedure' in considerable detail:

With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.

The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.

At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). Next he slides the tip of the middle finger along the spine towards the skull while applying tension to the shoulders and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

Reassessing proper placement of the closed scissors tip and safe elevation of the cervix, the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies

traction to the fetus, removing it completely from the patient.

The surgeon finally removes the placenta with forceps and scrapes the uterine walls with a large Evans and a 14mm suction curette. The procedure ends.

If that kind of procedure isn't child abuse, I don't know what is, Mr. Chairman.

Mr. Chairman, Several representatives of pro-abortion organizations will tell you today that most private insurance companies cover abortion in their health care plans. They will make this assertion without offering any credible evidence to verify it.

I expect that you will hear this claim from Planned Parenthood, among others. You should be aware, however, that Planned Parenthood's research affiliate-- the Alan Guttmacher Institute-- published a report on health care

reform in 1993 that contradicts this claim.

On page 12 of their report, AGI states that the insurance industry has viewed most reproductive health services as "elective measures ...contraception, sterilization, abortion and infertility services are often described as elective, and therefore, are excluded from coverage" the report states.

Since this report was published, the "party-line" of the pro-abortion groups and the Clinton Administration has changed. They now assert-- without credible documentation-- that most insurance companies cover abortion. This unfounded claim allows them to project themselves as the defenders of the status quo. Planned Parenthood President Pamela Maraldo told a luncheon audience on July 12, 1993 that "the inclusion of reproductive health services in a basic benefits package will truly constitute the 'defining moment' for reproductive benefits in America." These are not the words of someone defending the "staus quo."

Finally, Mr. Chairman, as you well know, Mr. Clinton both before and after entering the White House has insisted that he wants to make abortion

"rare." Yet his actions this past year suggest otherwise. On both the domestic and the international front, the President's policies have aggressively promoted abortion on demand.

Mandating abortion as a basic benefit seems to have been too much even for some of the President's advisors. David Gergen put the issue in stark terms when he wrote an article on this subject for U.S. News and World Report last year on April 19. "Apparently," Gergen wrote, "abortion is to be treated as a routine medical procedure easily available to all — no questions, no costs, no issues of morality or personal responsibility. This will make abortions 'rare'?"

Mr. Gergen acknowledges that the Clinton plan opens "the floodgates to universal abortion on demand, funded by taxpayers." Gergen adds "what we need, then, are policies that show compassion toward women as well as a high ethical regard toward unborn children. We stand in danger of having neither."

Mr. Gergen is right.

Mr. WAXMAN. I want to thank the three of you for coming here, waiting this long to give your testimony. It is obvious you have very strong feelings about it and want our committee to be clear that we must take those views into consideration.

I have no questions, but I do want to see if Mr. Bliley——

Mr. BLILEY. I just have a couple.

Mr. Hyde, Henry, the House voted in 1993 on your Hyde amendment with the inclusion for funding for rape and incest. What was that vote, do you remember?

Mr. HYDE. Well, we won in the House by an 85 vote margin and we won in the Senate by a 19 vote margin.

Mr. BLILEY. Now, under this plan as proposed by the President, the basic package would cover elective abortion. Does not cover cosmetic surgery, but would cover elective abortion. That means that every religious institution in the United States that has employees would have to provide and pay for this?

Mr. HYDE. That is right. Cardinal O'Connor and all of his employees, their taxes would go to pay for abortions.

Mr. BLILEY. Thank you. That is all, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Wyden.

Mr. WYDEN. Mr. Chairman, just one, and I share the view of the chairman, we have these debates on the Floor often and we do not need to have them here. I just want one question for the record.

I would be interested in knowing whether my colleagues favor the inclusion of contraceptive services for women in the national benefit package, and maybe, Mr. Smith, you could tell us your view, Mrs. Vucanovich, Mr. Hyde. Mr. Smith?

Mr. SMITH. My feeling would be as long as it is a nonabortive means, that is to say not one of these methods I have described—because, unfortunately, many people try to blur the distinction. They even try to construe such things as RU486, which often destroys the child somewhere around the seventh week of gestation, to be contraception.

But if you are talking about true contraception, where you are preventing life from ever coming into existence, whether through condoms or some other means, I have no problem with that.

The issue, as I engage it and what I am concerned about, is the taking of human life and that in order to be inclusive, the politics of inclusion, the policies of inclusion cannot disenfranchise an entire group, a class, boys and girls, of all races and colors, simply because they are unborn. Life does not begin at birth. Birth is an event that happens to each and every one of us, and these children before birth are worthy of respect, and that is all we are saying and hoping that this committee will take into consideration.

Mrs. VUCANOVICH. I would just concur with Chris Smith, that if we are talking about taking life, I would object. But preventive medication, preventive whatever, I have no problem with that.

Mr. HYDE. I agree with my colleagues, contraception truly, as distinguished from an abortifacient, I have no problem with.

Mr. WYDEN. I appreciate having that for the record.

I took special note of your point about the science, Mr. Hyde, and I think you have been consistent in taking that position. I think the scientists are going to tell us quite soon that we have what

amounts to a contraceptive morning-after pill, and then we will undoubtedly be talking about that on the Floor as well.

Mr. HYDE. My understanding is it takes 36 hours or so before fertilization occurs. So anything that intervenes before fertilization is truly contraceptive.

Mr. WYDEN. Mr. Chairman, thank you.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I think the members of the panel know I am strongly pro-choice, but I would hate to see this aspect of the health care debate derail whatever health care plan about which we can derive a consensus.

As I listen to your arguments, and I tried to listen closely, at least one of our essential themes is the notion that, as Congressman Smith indicated, there are conscientious objectors to abortion. We all recognize and respect that, certainly.

Congresswoman Slaughter testified prior to this panel and she talked about the fact there may be those that would object to paying for health care costs related to smoking because individuals make a life-style choice which many members of society find very objectionable. I think you could probably find members of our society who would object to having their tax dollars pay for drug and alcohol treatment because they would consider that a self-induced malady. You could probably find someone who would argue that with regard to sexually transmitted diseases, obesity perhaps, and the like.

I certainly recognize what the vote was on the Hyde amendment and know that, as Congressman Hyde always says, if a bill contains a mandate for reproductive choice, it starts very much in the hole in both chambers of the Congress.

The question that I have is, is there a way in your minds to take care of the conscientious objection of those who say I don't want to take my tax dollars, or my premium dollars, for that matter, and contribute it towards someone else's abortion? Can we allow them to opt out as opposed to opt in?

In other words, I find unacceptable the notion that a woman would have to pay in advance for extra coverage to provide for her abortion. But what about the notion of a woman or man saying to his or her employer, I don't need any coverage—I suppose this would not apply to men—but a woman saying I don't need any coverage for abortion so, therefore, please eliminate that from my personal individual coverage and reduce my premium accordingly by some factor that I am sure could be calculated?

That would seem to provide some solace for the conscientious objectors without derailing this debate. Do you find room for consensus there?

Mr. SMITH. If I could respond briefly. The employer would still have the problem who if he himself or she herself were against abortion of being complicit in the taking of human life. And when you mention such things as STD's and health care for people perhaps whose problems are with smoking or something of that kind, where there is some kind of behavior that led to their problems, we are talking still about curing. Whether it be removal of a lung be-

cause of lung cancer or some other kind of mitigation effort that the doctor initiates, it is to cure.

The difference, the fundamental difference in all of this is that in abortion, unless one construes a baby to be something other than a human being or human life, as being treated as if he or she was that tumor, it is destructive as opposed to curative. That is the fundamental difference.

That is why I think this puts it in terms of an ethical issue head and shoulders above perhaps almost any other hypothetical one might think of. Because, again, we are trying to cure in all of those other areas. We are saying you should not have smoked but you have lung cancer and we want to help you. In this case, we are saying there is a baby involved. We do not want to provide the poisons or the suction machines or whatever the means, the D&X that this Ohio abortionist extols as a way of preventing late term children who survive the procedure when there is no skull and no brain left. That is destructive, though, and that is the fundamental difference and that is why so many Americans, three out of four according to most polls, are so adamantly opposed to its inclusion as a basic benefit.

It ought to be elective. Some people may decide they want to buy insurance, but it cannot be a government mandate from our point of view.

MR. GREENWOOD. I certainly recognize you are not going to find congruency on opposite sides of this debate, but I am looking for some compromise, some common ground.

Certainly you are quite correct, the employer who has a conscientious objection would be paying at least 80 percent of the premiums for those who elect to have the coverage as part of their package. But it would seem to me that we would give that employer a fair amount of solace, again to use that word, in knowing that at least he or she provided for his or her employees the opportunity to opt out.

MRS. VUCANOVICH. Mr. Greenwood, I just would comment that very often in policies that are now in effect, that—for instance, there are many women who reject maternity benefits because they are beyond that or they know they will not have children and so forth. So if you are looking for a compromise, I am sure there are ways to do that. But I think people who do object, number one, and also people who would never need maternity benefits and now do opt out of that type of coverage, I think if you are looking for consensus, that is a possibility.

MR. GREENWOOD. Thank you.

MR. HYDE. We will look at any language that anybody proposes because nobody wants to sink this whole proposition. I am not for the bill, frankly, but on other grounds. But I don't want to sink it on any particular issue that is resolvable, but I can't think of any way that can be done gracefully or efficiently.

I do think getting it out of the mandate and making it available for people that want it, to me, seems to be the simplest, but I would be happy to look at any language that anybody proposes.

MR. GREENWOOD. Thank you, members of the panel. Thank you, Mr. Chairman.

MR. WAXMAN. Any other Members? Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Congressman Hyde, I was just looking at these statistics, and as I looked at them I thought about some things I have heard you say from time to time.

Mr. HYDE. Thank you for remembering.

Mr. TOWNS. In your very eloquent fashion. The way you phrase things makes a difference.

As I look at the polls, the CBS/New York Times poll, I was wondering if it had been phrased differently, suppose it had said, would you support the Federal Government paying for your abortion as opposed to paying for it privately? I think we would find a different set of results if it was phrased differently.

Mr. HYDE. I don't dispute the fact that how the question is phrased is critical in all polls. Do you believe that the Supreme Court decision, et cetera, should be supported? There is a predisposition to say yes. But if you ask, do you believe the unborn child in your womb is entitled to life, liberty and pursuit of, you will get a yes on that too. So the way the questions are asked, I think, is important.

The question is on this March 1993 CBS/New York Times poll. Is this a fair or is it misleading or is it a biased way of asserting the question? Should abortion for women who want it be covered as a part of a basic health care plan or should it be paid for directly by the women who want it? That is kind of nonjudgmental. I don't think that is loaded. And the answer was should be covered, the total men and women, 23 percent. Men were 24 percent, women 22 percent; should not be covered, 72 percent. Men 72 percent, women 72 percent.

Now, they thought because of previous questions that were asked that may have been slanted. Not the question, but I think there were some prior questions on this poll that may have predisposed people to this. So they came back 3 months later, the same people, CBS/New York Times, and they asked the same question without the predicate to it, and the question was, should abortion for women who want it be covered as part of a basic health care plan or should it be paid for directly by the women who want it? And in that poll the figures were different, but not significantly different. The total should be covered was 25 percent, men and women very much the same; should not be covered, 66 percent. And the men were 66 percent, women 65 percent.

So the gross results were there both times. So I would be inclined, unless there is another way to phrase that, to think these are pretty valid.

Mr. TOWNS. The way I phrased it, the results might be different.

Mr. HYDE. Might be. Might be.

Mr. TOWNS. Let me put it another way, I guess to Mrs. Vucanovich. Just before you there was a panel of women, bipartisan group, and I would say to you without any question at all that the majority of the women in this Congress support abortion being in the package, and most of the women here arrived in the last 5 years. Now, they were able to go through elections and this question was probably an issue and people supported them even knowing that was their position. So why is it so different, and based on the num-

bers that we see here why would that be so different? Let me ask Mrs. Vucanovich that.

Mr. HYDE. OK.

Mrs. VUCANOVICH. Well, I don't know. I have been here for 11 years and I have never changed my position, so the same thing holds true.

Mr. TOWNS. But you agree to the fact that the majority of the women, bipartisan group here in the Congress, support abortion being in this package.

Mrs. VUCANOVICH. There is no question. There is no question. But, you know, I don't know how representative that is. I don't know how representative your views are, for instance, either. So I think that we are only 435 people here. I don't know. We are representative, I guess.

Mr. TOWNS. It is some indication, I think. Because someone voted for them to get here.

Mrs. VUCANOVICH. Well, they voted for me too.

Mr. HYDE. If I took a poll in my district about aid to Russia, it wouldn't even be close. On the other hand, I believe it is very important that we help in that transition from a Communist command economy to a democratic capitalistic economy. So sometimes we kind of get ahead of our own people sometimes. That may be good; that may be bad, but I think it is a fact.

Mr. SMITH. Can I just add that the polls showed consistently, in polls throughout the last decade, have showed consistently that the American public, with women often being in the majority as opposed to men, do not want to use government taxpayer funds for abortions. These numbers are even higher than those numbers, because now they know apparently they will be paying for every abortion.

It may be true, and I think it is true, that people here, perhaps, the congressional women have a feeling in favor of paying for it. But if the people who have to pay for it, the American public, the millions of taxpayers and employees and employers out there, the majority of which are women, have said in these polls after poll, no matter how the wording of the question is posed, that they do not want to pay for it, do we represent ourselves? Is this a closed inside-the-beltway thing? Or do we care about what the man and the woman on the street really think?

And that is what we are talking about. These polls, and I say it again, The New York Times has been not known, editorially at least, to be in sympathy with the pro-life perspective. When they issue this kind of report, I think we should stand up and take notice.

Mr. TOWNS. I have a poll here of people supporting abortion, but we have had this debate on the Floor many times so I will yield back. Thank you very much.

Mr. HYDE. Mr. Chairman, just one little shot here. Lou Harris, who is not exactly a favorite Republican pollster, generally known as a pollster for liberal activists, and here is how he asked the question, Mr. Towns.

Quote: Do you think that the basic health insurance benefits guaranteed to all Americans should include coverage for abortion or should people have to pay extra to have abortion coverage by

their insurance? That is October 1993. Lou Harris: Should be included, 27 percent. Should have to pay extra, 62 percent. Those are the facts.

Mr. SMITH. Mr. Chairman, may I just—

Mr. WAXMAN. Well, if I might move on. I was going to let you go without asking questions, but now I will recognize myself.

Mr. Smith, you seem to think that, as I understood the distinction you drew, that abortion is not a medical service because it is taking away life. Giving a woman prenatal care and helping her deliver the baby, that is certainly something you would think is a pro-life medical service.

Mr. SMITH. Absolutely, Mr. Chairman. If I could, there you are talking about nurturing both patients, mother and baby.

Mr. WAXMAN. Now, do you think that every woman ought to be able to have prenatal care and birthing services?

Mr. SMITH. Yes, I do.

Mr. WAXMAN. Do you think that undocumented alien women in this country ought to have that paid for?

Mr. SMITH. Frankly, I believe that any woman who is in need of health care, whether they be aliens or anyone else, and who is with child and in particular need ought to have that health care, yes.

Mr. WAXMAN. That was the position taken in testimony before our subcommittee by the Catholic bishops. They said they are for pro-life and, therefore, covering the unborn and the undocumented.

Mrs. Vucanovich, do you agree we ought to pay for the undocumented aliens in this country for their medical services?

Mrs. VUCANOVICH. I believe that we should take care of the women who need, who are pregnant and who need the care.

Mr. WAXMAN. You know, there are a lot of people in this country who do not think they want their taxpayer dollars to pay for health care services for undocumented aliens. They have come into this country illegally and they would take the attitude that it is wrong to give them that care because it will bring them into this country. It will be a magnet.

And I am not saying I agree with that point of view but there are a lot of people that agree with that point of view.

Do you think they should be able to say there should not be service in this bill; that women who come here ought to be denied that service; even if it meant that their children may be in jeopardy?

Mrs. VUCANOVICH. I would certainly vote for help for them.

Mr. WAXMAN. Would you say they should be able to withhold their taxes or premiums to cover something they find offensive like that? Offensive, even though you and I would call it pro-life.

Mr. SMITH. Again, you may call it offensive from some people's perspective, but still, what our view is, what my view is at least, and very strongly, that it is nurturing life as opposed to abortion, which takes life. That is the fundamental difference. Only abortion does that.

Mr. WAXMAN. A woman coming across the border in order to deliver her child in an American hospital is breaking the law to do it. A woman who goes to a hospital or to a clinic to have an abortion is living up to the law which says that is a service that is legally provided to her at her choice. You would reward somebody

who breaks the law but deny somebody health care who is abiding by the law; is that your position?

Mr. SMITH. The interesting thing here, you apparently agree those undocumented aliens likewise should receive the care from a humanitarian point of view, and I would be in sync with that.

Mr. WAXMAN. I want to reason this through with you. You are taking the position because a lot of people do not think abortion is proper, even though it is legal, they should not have to pay for it. Now a lot of people think coming to this country illegally is improper, certainly illegal, and they do not want to pay for it. I want to find out where we draw the line.

Mr. SMITH. We draw the line when medicine goes over the line and takes life rather than cures and provides help to life and ceases nurturing.

Mr. WAXMAN. You just don't think abortion should be legal. It ought not to be done. That is your view. I respect that view, but it is not the law of this country. There are a lot of people who think, as I read in the newspapers, I have some of the clips, Reverend Farrakhan thinks because I am Jewish that is an abhorrent thing to him, but the Constitution of the United States protects me to have my religious beliefs. I would not want it any other way, nor would you, but the Constitution of the United States also protects the right of a woman to make a decision that you think is wrong but it is nevertheless her constitutionally protected right.

Mr. SMITH. That does not require we pay for it, and that is the bottom line here.

Mr. HYDE. You can never go wrong protecting the innocent defenseless little ones. Protecting them. Assaulting them, exterminating them is wrong. But protecting them, whether they are illegal, whether they are legal, they have committed no crime. They have not broken any law. They are there involuntarily and you should think of them and protect them.

Mr. WAXMAN. So your position would be that we ought to cover and pay for, if they cannot otherwise pay for—

Mr. HYDE. I would find some other way to punish the violation of the law.

Mr. WAXMAN. Excuse me, I want to get you on the record. You are for having the taxpayers of the country pay for the health care of a pregnant woman who is coming here illegally and to give her the—

Mr. HYDE. I am for denying citizenship to her offspring, but I am for taking care of the health needs of a tiny, defenseless, vulnerable, can't vote, can't defend themselves infant, pre-born infant, yes. Sure. I have no problem with that. You might because you are from California but I don't.

Mr. WAXMAN. Well, I might take an opinion poll to decide what my views would be on the issue.

I want to recognize any other Members that want to ask questions because this is an opportunity to do it.

Well, you certainly have given us a lot to think about and we appreciate your being with us.

Mr. HYDE. Thank you.

Mr. WAXMAN. Our next panel is made up of representatives of the administration, who will describe the President's health care proposal and its relations to women's health.

Our first witness is Dr. Judith Feder, who is making her second appearance before the subcommittee this week and her fifth appearance on health reform. The second witness, Dr. Sam Broder, is the Director of the National Cancer Institute and is also a familiar figure before this subcommittee. Both witnesses are accompanied by Dr. Susan Blumenthal, the Deputy Assistant Secretary for Women's Issues.

We want to welcome you to our committee. Your prepared statements will be in the record in full. We would like to ask you, however, to limit the oral presentation to no more than 5 minutes.

Dr. Feder, why don't we start with you.

STATEMENTS OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND SAMUEL BRODER, DIRECTOR, NATIONAL CANCER INSTITUTE, NATIONAL INSTITUTES OF HEALTH, ACCOMPANIED BY SUSAN BLUMENTHAL, DEPUTY ASSISTANT SECRETARY FOR WOMEN'S HEALTH

Ms. FEDER. Thank you, Mr. Chairman. It is a pleasure to be here again. I am pleased today particularly to be here to talk to you about women's health under the Health Security Act. The act represents the President's commitment to all Americans but particularly to American women as workers, mothers, daughters, and caregivers.

The Act guarantees the kinds of care and research that are needed to protect women's health and to guarantee comprehensive care for all women. The Act is designed to address many of the barriers that women face today. Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs, jobs which usually do not offer health insurance to employees.

Many women must rely on their spouses for health insurance and risk being dropped if they are divorced or widowed. Women are especially likely to change their work status during their childbearing and child rearing years, causing them to risk losing their health insurance benefits.

Mr. Chairman, the Health Security Act addresses many of these barriers by guaranteeing every woman health insurance protection regardless of employment status, health, income or age. The Act allows every woman to maintain health coverage even if she switches her job or loses her job with no interruption in health care delivery or change in choice of physicians.

The act eliminates preexisting condition clauses, which are often used to exclude women from receiving prenatal care coverage and other important benefits. The Act provides a benefit package that includes a broad range of health services and that focuses on prevention and primary care, services particularly important to women.

Finally, the Act includes provisions for enabling services for women who face access barriers such as lack of transportation that makes it difficult to obtain needed care.

First, let me focus on the benefits. A dramatic step forward, the Health Security Act will focus on primary and preventive services in every insurance plan. This will enhance a woman's ability to obtain services such as prenatal care, mammography, Pap smears, contraceptive drugs and devices, family planning counseling and services, and mental health services. It is particularly important that reform will provide greater access to screening for breast and cervical cancers, including mammograms and Pap smears with no cost-sharing.

The plan also includes coverage for the full range of pregnancy-related services. The choice of necessary or appropriate services will be left to a woman and her health care provider. To encourage their use, prenatal care and one postpartum visit are covered with no cost-sharing. Delivery care is covered and may have cost-sharing depending upon the woman's particular plan. Voluntary family planning services, including all contraceptives that are approved by the FDA and are dispensed by prescription, will be covered. Women at risk for sexually transmitted diseases can be screened with no cost-sharing.

Now let me turn to women as mothers. The Health Security Act also gives women the security that their children will have access to health insurance and to guaranteed benefits. The comprehensive benefit package includes childhood immunizations, regular check-ups, and preventive services for children, including vision and dental care.

We know women are also caregivers for people and their families with disabilities and we are particularly concerned about the later years of life for women and for their loved ones. Women provide much of the long-term care for their families, however, because women generally outlive men, they find themselves without caregivers in their time of need for such services.

The new long-term care program in the Health Security Act will provide a range of community support to people with severe disabilities, regardless of their age or income. A principal goal of this new program is to increase the independence of people with disabilities, support them to remain in their own homes or in other community settings, and reduce the burden on family members and other informal caregivers, most of whom are women who are struggling so hard to keep them at home.

When it comes to research, the Health Security Act calls for an expanded program of prevention research at the National Institutes of Health that are particularly important to women. Among the research priorities outlined in the bill are mental health, substance abuse, reproductive health, child and adolescent health and breast cancer.

The President recognizes that insurance alone cannot meet the needs of the health of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act also includes several new investment proposals that are particularly important to adolescents and young women. These include grant programs for school health education and for school health services. It also includes support for urban and rural medically underserved populations through a number of initiatives.

Mr. Chairman, the Health Security Act was designed to guarantee all women access to comprehensive health care. The President has taken a bold step in spelling out this guarantee. Every woman can be assured that she will have the benefits that she needs and all women will have access and coverage in a revitalized health care system that prevents disease and promotes health but is also there when they or their loved ones are ill.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Feder.

[Testimony resumes on p. 81.]

[The prepared statement of Dr. Feder follows:]

STATEMENT OF

JUDITH FEDER, Ph.D.

PRINCIPAL DEPUTY ASSISTANT SECRETARY

FOR PLANNING AND EVALUATION

Mr. Chairman and Members of the Committee:

Thank you Mr. Chairman.

I am pleased to come before you today to talk about women's health under the Health Security Act. The Act represents the President's commitment to all Americans, but particularly to American women. The Act guarantees the kinds of care and research that are needed to protect women's health and to guarantee comprehensive care for all women.

The President's Health Security Act is committed to guaranteeing that all women have access to preventive and diagnostic services that are so critical to their physical and emotional well being.

The Act is designed to address many of the barriers women face today:

- Women, because on average they earn less than men, are disproportionately affected by soaring health care costs. Health care reform will make insurance affordable and keep down out-of-pocket expenditures.
- Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs-- jobs which usually do not offer health insurance to employees.

- Many women must rely on their spouses for health insurance, and risk being dropped if they are divorced or widowed.
- Women are especially likely to change their work status during their child bearing and child raising years, causing them to risk losing their health insurance benefits.
- In 1992 there were over 2 million uninsured children under 18 living in families that are headed by single women. Women bear a major responsibility for the health needs of uninsured children.
- Women make up nearly four fifths of the informal caregivers who assist the more disabled elderly -- that is, those who need help with one or more basic daily living tasks, including bathing, dressing, transferring, toileting or eating.
- Women tend to live longer and require more long-term care and home health services that are often not affordable or available.

Mr. Chairman, the Health Security Act addresses many of these barriers by guaranteeing every woman health insurance protection

regardless of employment status, health, income or age. The Act allows every woman to maintain health care coverage even if she switches jobs or loses her job - with no interruption in health care delivery or change in choice of physicians. The Act eliminates pre-existing condition clauses which are often used to exclude women from receiving prenatal care coverage and other important benefits. The Act provides a benefit package which includes a broad range of health services and which focuses on prevention and primary care, services particularly important to women. Finally, the Act includes provisions for enabling services for women who face access barriers such as lack of transportation.

GUARANTEED BENEFITS

One of the most significant parts of the Health Security Act for women is the guarantee of comprehensive benefits for all. This is particularly important because of the serious health problems women face today. For example:

- One in eight women in the U.S. will develop breast cancer in her lifetime. In the United States 1.6 million women have breast cancer today, and this year approximately 182,000 American women will be diagnosed with the disease, approximately one woman every three minutes.

- In 1990, only 49 percent of women age 50 and above had a mammogram in the previous two years. And in 1992, women earning under \$10,000 a year were 30 percent less likely to have had a mammogram in the last year than women earning more than \$20,000.
- In 1991 early prenatal care was received by less than 2/3 of black, Mexican American, Puerto Rican, Central and South American, or American Indian mothers. Pregnant women who receive no prenatal care or care only in the final trimester are more likely to have a low birth weight baby, to have their baby die, or to die themselves of pregnancy-related complications.

The Health Security Act will address many of these problems because it will focus on primary and preventive care. This will enhance women's ability to obtain services such as prenatal care, mammography, pap smears, contraceptive drugs and devices, family planning counseling and services, and mental health services.

It is particularly important that reform will provide greater access to screening for breast and cervical cancers. Without action to increase high quality screening and follow-up services, breast and cervical cancer will take the lives of more than one-half million women during the 1990s. Poor, elderly and minority women are least likely to be screened for breast and cervical

cancer. Women with low incomes, particularly those who are uninsured, often have difficulty obtaining these services. Under the Health Security Act, women will be guaranteed a comprehensive package of benefits that will include unprecedented coverage of a wide range of clinical preventive services, including mammograms and Pap smears with no cost-sharing.

The plan also includes coverage for the full range of pregnancy-related services. Prenatal care and one post-partum visit with no cost-sharing to encourage their use. Delivery care is covered, and may have cost-sharing depending on the woman's plan. Voluntary family planning services, including all contraceptives that are approved by the FDA and are dispensed by prescription, will be covered. As with other services, the choice of necessary and appropriate reproductive health care services will be left to a woman and her health care provider. Women at risk for sexually transmitted diseases can be screened with no cost-sharing. When additional testing is medically necessary or appropriate, such as when a woman presents symptoms, it will be provided with cost-sharing.

The clinical preventive services included in the President's plan are based on our best scientific information, including the recommendations of the U.S. Preventive Services Task Force. In addition, our mammography benefits are consistent with those recently recommended by the National Cancer Institute (NCI) which

found that routine screening mammography in women over the age of 50 will reduce the risk that a woman will die of breast cancer by approximately one-third. In a dramatic step forward, clinical preventive services are provided at no charge to detect disease early and to encourage healthy behaviors.

Covered services include the following:

- Women age 20-39 will be covered for physical examinations every 3 years with no cost-sharing, including pap smears and clinical breast exams.
- Women age 40-49 will be covered for physical exams every 2 years with no cost-sharing, including pap smears and clinical breast exams.
- Women age 50-64 will be covered for physical exams every 2 years with no cost-sharing, including pap smears and clinical breast exams. In addition, these women can receive mammograms every 2 years with no cost-sharing.
- Women who are defined as high risk for certain medical conditions will also be eligible to receive additional services, or more frequent tests, including mammograms or pap smears, with no cost-sharing.

Independent of these clinical preventive services women of any age can receive health care services, including clinical breast exams and mammograms, at any time when it is medically necessary or appropriate, with cost-sharing, depending on their plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

Some of the most common mental disorders, including depression and some anxiety disorders, strike approximately twice as many women as men. The substance abuse and mental illness benefits will provide important services for Americans with these disorders including the elimination of preexisting condition exclusions and lifetime limits.

WOMEN AS MOTHERS

The Health Security Act also gives women the security that their children will have access to health insurance and to guaranteed benefits. The comprehensive benefit package will include childhood immunizations, regular check-ups, and preventive services for children, including vision and dental care.

WOMEN AS CAREGIVERS

We know that women are particularly concerned about the later years of life for themselves and for their loved ones. Women

provide much of the long-term care for their families. However, because women generally out-live men, they find themselves without caregivers in their time of need for such services.

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all women and their families in America. But women who need long term care or who have relatives with chronic health problems or severe disabilities face special challenges.

The new long-term care program will provide a range of community supports to people with severe disabilities, regardless of their age or income. A principal goal of this new program is to increase the independence of people with disabilities, support them to remain in their own homes or in other community settings and reduce the burdens on family members and other informal caregivers, most of whom are women.

WOMEN'S HEALTH RESEARCH

Women are more likely to have greater disability and poorer health outcomes than men and the incidence of certain life-threatening illness is increasing among women, yet they have been at the bottom of the medical research agenda. The Act calls for an expanded program of prevention research at the National Institutes of Health. Among the research priorities outlined in

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the bill are including birth defects, prenatal care, and adolescent health, mental health, substance abuse, reproductive health, breast cancer and Alzheimer's disease. The bill would authorize \$400 million for fiscal year 1995, and \$500 million for each of the fiscal years 1996 through 2000.

OTHER INVESTMENTS

The President recognizes that insurance alone cannot meet the needs of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals that are particularly important to adolescents and young women.

First, the Act includes two new grant programs to support school health education programs and to fund school health services. Under the Act, \$50 million in FY 1995 will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes \$100 million in FY 1996 rising to \$400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and

injuries and referral and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

New funding also will be authorized to help support public health initiatives of special importance to the health of children including immunizations, lead poisoning screenings, health education and violence prevention.

To ensure access to health services for urban and rural medically underserved populations, the Act calls for expanding the Community and Migrant Health Center program. An additional annual appropriation of \$100 million for the years 1995 through 2000 would be authorized by this bill. The Health Security Act also proposes to establish a program of grants and loans for consortia of public and private health care providers to develop community practice networks or community health plans.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors (including pediatricians, obstetricians and family physicians) and other health professionals (including nurse clinicians) to ensure that children and expectant mothers will have access to appropriate medical care.

CONCLUSION

Mr. Chairman, the Health Security Act was designed to guarantee all women access to comprehensive health care. The President has taken a bold step in spelling out that guarantee. Every woman can be assured that she will have the benefits that she needs. All women can now have access to a revitalized health care system that prevents disease and promotes health, but is also there when they or a loved one becomes ill.

Mr. Chairman, I'd be happy to respond to questions.

Mr. WAXMAN. Mr. Broder.

STATEMENT OF SAMUEL BRODER

Mr. BRODER. Good morning, Mr. Chairman.

Mr. WAXMAN. You need to push the button forward on the mike.

Mr. BRODER. Probably would have been better for me to leave the button off, but good morning, Mr. Chairman, and members of the subcommittee.

I am Dr. Sam Broder, director of the National Cancer Institute. Thank you very much for the opportunity to appear before you today and to provide a very brief set of opening remarks.

Mr. Chairman, with your permission I would like to submit my complete statement for the record and begin by saying science and the scientific method offer our best hope for progress against terrible diseases like breast cancer and cervical cancer, diseases which cause suffering beyond metaphor.

The specific issue of mammography is an area of intense polarization between various groups at this time. This polarization has occurred not because of fundamental differences—we all share the concern that women are dying of breast cancer—but because we have different perspectives on this problem.

The National Cancer Institute is a scientific institution, a biomedical research institution committed to generating the knowledge needed to reduce the suffering and death from cancer. While at times there have been bursts of enthusiasm for research advances that promised to cure cancer, we all recognize that cancer has, in fact, not been cured. We know that cancer poses an awesome research and therapeutic challenge. We must have no illusions on this point.

As a scientific organization, we know that individual opinions and practices may require adjustments or even fundamental changes as we continue to learn. At the same time, we have seen that yesterday's, quote, "incurable and fatal", end of quote, disease can be tomorrow's medical triumph, and that a disease that terrorizes one generation may be only dimly remembered by the next generation.

Two principles need to guide us, if at all possible: One, the consensus of scientific peer groups and/or, two, clinical trials as the instrument for consensus wherever possible.

We could not advocate a treatment being continued if follow-up clinical trials showed that its benefits were initially overstated, that in truth, it brought no reduction to deaths in the real world.

And, indeed, National Cancer Institute-sponsored focus groups and surveys show overwhelmingly that American women understand that scientific controversy can exist in many arenas and women would prefer to know the facts to help them make informed decisions rather than operate on blind faith.

After a process of scientific evaluation, after extensive review of data from a number of clinical trials, after internal and external debate, and after seeking the input and advice of our most respected nongovernmental experts, we have an obligation to share the results of this process with the women of America.

Mammography has been proven to reduce the death rate due to breast cancer in randomized clinical trials for women over age 50,

and moreover, there is a clear and unmistakable consensus on this point. For women under 50, neither condition applies at this time.

One point must be emphasized: This discussion does not address diagnostic mammography, where a doctor and woman are joined in following symptoms or other indications, such as a lump, pain, or swelling, or a related issue suggesting a possible malignancy. That is a different situation entirely and mammography in this setting is a valued tool to establish a course of diagnosis and treatment in women of any age. In this discussion, we are focusing on the concept of mammography screening in women who are free from known signs or symptoms.

The rank-and-file scientists who work in the national cancer program are superb and dedicated. They are working to find new ways to prevent, detect, and treat breast and cervical cancer.

We have many molecular studies under way and already have had some success. We are hopeful that research discoveries will yield new molecular tests that might have high specificity.

But we are not waiting for these events to occur. We are encouraging the development of new digital mammography techniques and related issues. We are exploring new technologies such as magnetic resonance imaging, and even electronic paramagnetic spin resonance, a novel technology which is still in its earliest infancy.

I think these are all issues to keep in mind as we discuss all the points.

I have included a brief history of NCI screening recommendations in my complete statement submitted for the record. To summarize it very briefly, in 1987, the NCI developed working guidelines for the early detection of cervical and breast cancers. The intent was to revisit them should any new information become available, as has been proven to be the case.

I will not recount all of the background, but one of the formative events was the Canadian national breast screening study, which tested mammography screening for women in their forties, published in November 1992, turned out not to show a mortality benefit ascribed to mammography after 7 years of follow-up.

In addition, an overview analysis of five randomized screening trials conducted in Europe in the 1970s found that the largest reduction of breast cancer, roughly one-third, was observed among women aged 50 to 65 at randomization. Among women aged 40 to 49 at randomization, no statistically significant difference was observed.

The process of taking stock as to where we were was actually initiated in 1991 and a detailed account is in my written statement.

In the fall of 1991, as we became aware of the then unpublished results of the Canadian mammography study completed and viewed in the context of the other results at hand, NCI was prompted to organize a major international workshop of breast cancer screening that was, in fact, held in February of 1993.

This workshop was open to both the press and public at the same time. NCI provided information and resources to all interested parties on the mammography screening studies that were being reviewed and were discussed. The workshop was thorough, rigorous, and a careful process of deliberation and consultation continued

after the workshop adjourned. This consultation process included outreach activities involving women who care about breast cancer.

During October of 1993, NCI disseminated draft guidelines and presented them at the NCI DCPC Board of Scientific Counselors. This is the body that is equipped to advise us on highly technical cancer control and prevention activities.

At that time, this board passed a motion recommending that the existing recommendations for women 50 years and over be maintained, but that for women under age 50 NCI provide a summary of existing data. In effect, that board wanted to present the facts without the pronouncement of a guideline, but this process did not unfold without controversy.

In late November of 1993, yet another advisory body, the National Cancer Advisory Board, passed a motion recognizing the divergence of views on the role of mammography for women under the age of 50 and recommending that the National Cancer Institute actually defer action on recommending any changes in breast cancer screening guidelines.

On December 3, after having considered all of the facts and all of the advice, we released a simple statement of our position on breast cancer screening and a statement that is basically in accord with the recommendation of the Board of Scientific Counselors. We believe this process has been open and candid. We have extended our outreach to many diverse groups, both scientists and consumer advocates. None of us is content with the level of progress against breast cancer. We know the suffering caused by this disease.

Mr. Chairman, I welcome your interest and the interest of the members of this committee. We need, and I believe we are using, the best tools of modern biomedical science to help us find the truth. When we make a recommendation, women have the right to ask about the facts that inform such a recommendation. Our recommendations must be based on scientific evidence and scientific consensus. We will not rest until we have a cure for breast cancer. We owe that to the American people.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Broder. I appreciate your testimony, but let me start off the questioning.

[The prepared statement of Dr. Broder follows:]

Statement of Dr. Samuel Broder
National Cancer Institute

Good morning, Mr. Chairman, and Members of the subcommittee. I am Dr. Samuel Broder, Director of the National Cancer Institute (NCI). Thank you for the opportunity to appear before you today to discuss the NCI's position, and the scientific basis for that position, on screening for breast and cervical cancers, two areas critical to women's health.

Cancer is the second leading cause of death among women in the United States. In 1994, about 250,000 women will die of all cancers combined, about 46,000 dying of breast cancer. It is the most common cause of death from any cause in women aged 40-44. Since 1987, breast cancer incidence, fortunately, has reached a plateau and has actually decreased slightly. However, from 1973 until 1987 the incidence of breast cancer showed a steady increase. Although there are now slight decreases, the situation is dire. Some of the past increase in incidence over the 1980s is attributed to increased detection due to mammography; the longer term increase is less well understood. We do not believe that the increase can be fully understood without more basic research.

Turning to cervical cancer, in 1993, 13,500 American women were diagnosed with this disease and 4,400 died. Fortunately, the incidence of invasive cervical cancer and the death rate have decreased in the United States over the past several years, because the Pap screening test can detect the pre-malignant or in situ stage. The Pap test, developed by George Papanicolaou, has been used since the 1940's. This test, like others, has limitations. The early stage can be effectively treated, and yet, even here, there are problems as sometimes the cells captured during the procedure are not the atypical ones. Beyond that, some women are not being screened at all and even among those who are screened, some are not being treated. Even when the cells are accurately gathered, not all tests are read and interpreted accurately. NCI has worked to improve the reading of the Pap test and has introduced the "Bethesda system" which has clarified and standardized reporting. Despite these problems, the Pap test is an excellent tool, even when its limitations are taken into account. As a result of our investment in basic research, we are making good progress on a possible vaccine against cervical cancer. The ability to create such a vaccine grew out of years of research on viral carcinogenesis.

The issue of mammography is an area of intense polarization between various groups at this time. The polarization has occurred not because of fundamental differences--we all share the concern that women are dying of breast cancer--but because we have different perspectives on this problem. The key question before us all is how to go about reducing the devastating toll of breast cancer and other cancers.

The NCI is a scientific institution, a biomedical research institution committed to generating the knowledge needed to reduce the suffering and death from cancer. While at times there have been bursts of enthusiasm for research advances that promised to cure cancer, we all recognize that cancer has not been cured. Today, there are exciting developments on many fronts, particularly in basic research, but as we discuss these achievements, we must

acknowledge that cancer poses an awesome research and therapeutic challenge. We must have no illusions on this point.

As a scientific organization, we know that individual opinions and practices may require adjustments or fundamental changes as we learn more facts about normal biology, more about the cancer cell and have more opportunity to assess diagnostic tools and treatments. At the same time, we have seen that yesterday's "incurable and fatal" disease can be tomorrow's medical triumph, and that a disease that terrorizes one generation may be only dimly remembered by the next generation. Two principles need to guide us wherever possible: the consensus of scientific peer groups and clinical trials as the instrument for consensus wherever possible.

Each of us has a role to play in this enormously important effort to save the lives of American women. I believe that NCI's role is the generation of knowledge, the sharing of that knowledge and translation of scientific knowledge into clinical reality at the community level. We could not advocate a treatment being continued if followup clinical trials showed that its benefits were initially overstated, that in truth, it brought no reduction in deaths in the real world. By the same rules, we must adhere to what we have learned about the value of mammography for women in various age groups. After a process of scientific evaluation, after extensive review of data from a number of clinical trials, after internal and external debate, and most important of all, after seeking the input and advice of our most respected non-governmental experts, we have an obligation to share the results of this process with the women of America. We owe it to them to provide the most accurate information available about screening and treatment of breast and cervical cancer at a point in time. In the case of mammography, a routine program of screening will definitely save lives. This technology has been proven in randomized clinical trials for women over age 50, and moreover there is a clear and unmistakable consensus on this point. For women under 50, neither condition applies at this time.

One point must be emphasized: this discussion does not address diagnostic mammography, where a doctor and woman are joined in following symptoms or other indications, such as a lump, pain, or swelling, of a possible malignancy. That is a different situation entirely. Here, in this discussion, we are focusing on the concept of screening in women who are free from known signs or symptoms.

It is important to note that mammography is only one of several screening technologies being examined by NCI. For example, a large clinical trial, the Prostate, Lung, Colorectal, and Ovarian (PLCO) trial, has begun to evaluate screening tests in these cancers. This study will assess the predictive value of the widely used test for prostate specific antigen (PSA) and less used technology such as ultrasound, CA 125 or flexible sigmoidoscopy. In women, for instance, the study is designed to determine if screening with pelvic examination plus serum CA 125 and transvaginal ultrasound can reduce deaths from ovarian cancer. Thus, for tests such as PSA, we are not recommending its adoption as a routine screening tool until clinical trials and/or a scientific consensus permit us to do so.

The rank-and-file scientists who work in the National Cancer Program, both intramural and extramural, are superb and they are a dedicated group of men and women. They are working to find new ways to prevent, detect and treat breast and cervical cancer. NCI supports research aimed at locating important genes and genetic processes in breast cancer. Research is being carried out on specific inherited gene abnormalities and certain familial predispositions to breast cancer including benign proliferative breast disease; the Li-Fraumeni syndrome, in which family members inherit a mutation in the p53 tumor suppressor gene, located on the short arm of chromosome 17; and early-onset familial breast cancer, linked to abnormalities also on chromosome 17 referred to as Breast Cancer-1 or BRCA-1.

Collaborations with the National Center for Human Genome Research are designed to elucidate genetic information about breast cancer. On December 2, 1993, we were pleased to announce the finding of a gene for colon cancer that also appears to play a role in ovarian, uterine and several other cancers. When genes are found, tests can be developed to show which women are at risk. Sometimes the genetic discovery will aid in developing vaccines or new prevention strategies.

At times, conditions not typically thought to fall within a definition of women's health are of surpassing importance. Thus, the gene for Ataxia-Telangiectasia when carried by an otherwise normal woman can predispose her to radiation damage and breast cancer. As carcinogenesis studies progress, this information could be used to counsel women at high risk to avoid certain environmental exposures and to undertake individualized programs of screening and prevention. We are looking specifically at breast cancer and the interaction of various occupational and environmental hazards in the NCI Long Island Breast Cancer Study Project. This will provide information not only for New Yorkers, but for women everywhere.

Genetic discoveries will yield new molecular tests that might have high specificity. We are not waiting for these events to occur. We are working to refine our knowledge of the tools we have, including mammography and Pap tests. We are encouraging the development of new digital mammography techniques, which would also allow transmittal of images for consultation or diagnosis by specialists. New imaging techniques are being used to more accurately guide biopsies and surgery. Other methods are borrowing from space or defense department technology. None of us is content. All of us know that cancer is the second leading cause of death among women in the United States and we know the suffering caused by this disease.

NCI research has shown that the impact of cancer in general on minority and underserved populations is disproportionately great. This impact is certainly felt in breast and cervical cancer incidence and mortality rates. Even where incidence rates are lower for African-American women than for white women, as is the case with breast cancer in women ages 40 and over, the mortality rates of African-American women are higher. Cervical cancer incidence rates for African-American women are about twice the rates for white women, and mortality rates are about three times the rates for white women.

Screening and access to screening are only one aspect of this very complex situation, one that tangles economic issues, educational issues, access to screening and diagnosis and access to treatment with many other variables including genetic and environmental ones.

Mammography has seemed to be a successful way to introduce some underserved women into the medical system. In some ways, it has become a metaphor for concern about breast cancer, even a way a woman could express her determination to protect her health. But mammography was never designed to do all that--it is a medical tool. Mammography was designed to screen for breast cancer and where it is efficient and there are other benefits, that is all to the good. Thus, for women over 50, mammography is an established screening tool. But there is extreme disagreement concerning women under age 50. Therefore, in this setting, we must state what we know and what we do not know.

A word about the history of NCI recommendations is in order. In 1987 the NCI developed Working Guidelines for the early detection of cervical and breast cancers. These guidelines provided the American public with a summary of the state of knowledge at the time.¹ The guidelines regarding screening mammography for breast cancer detection (which can be defined as a regularly performed mammogram for a woman with no presumptive evidence or symptoms of breast cancer) were as follows:

- ♦ The screening process should begin by age forty and consist of annual clinical examination with screening mammography performed at one to two year intervals.
- ♦ Beginning at age fifty both clinical examination and mammography should be performed on an annual basis.
- ♦ Physicians should encourage women to perform monthly breast self-examinations.

At the time these guidelines were developed, evidence for screening was strongest in women ages 50-69, although the Health Insurance Plan (HIP) of Greater New York clinical trial had shown a reduction in cancer deaths due to screening in a group of young and older women all mixed together. The above guidelines were considered working guidelines with the intent to revisit them should any new information become available.

Similarly, the working guidelines for cervical cancer screening developed in 1988 are as follows:

¹ It is important to stress that none of these guidelines pertain to diagnostic mammography, which is performed as a result of a clinical suspicion (such as a lump or nipple discharge). In the setting of a clinical suspicion, whether because of symptoms or physical findings, mammography is generally a necessary medical tool.

- ♦ All women who are or who have been sexually active or who have reached the age of 18 years should have an annual Pap test and pelvic examination.
- ♦ After a woman has had three or more consecutive, satisfactory, normal annual examinations, the Pap test may be performed less frequently at the discretion of her physician.

Over the ensuing six years there has been no new information to contradict the basic message of the original guidelines on cervical cancer and the consensus among scientists has held firm. Over the last two to three years, however, several events have led to an ongoing re-evaluation of the breast cancer screening guidelines:

- ♦ First, an NCI-supported meeting entitled "Forum on Breast Cancer Screening in Older Women" was convened in April 1992. Among the recommendations was the following: "There was enough direct evidence to support a recommendation for universal screening in women sixty-five to seventy-four years of age. Because of the lack of direct evidence regarding screening efficacy and because of increasing occurrence of multiple chronic diseases in women seventy-five years of age and older, the Forum concluded that clinical judgment was necessary to weigh the relative benefits of co-morbidity and screening effectiveness for the individual patient in this age group ... Regarding the interval for mammography and clinical breast examination, the Forum concluded that there was no evidence to choose one interval over another, since apparently equally effective intervals have ranged from twelve to thirty-three months."
- ♦ Second, the Canadian National Breast Screening Study of screening women in their forties, published in November 1992, did not show a mortality benefit ascribed to mammography after seven years of follow-up. Dr. Anthony Miller presented a preliminary analysis of this study in closed session to the Board of Scientific Counselors of the NCI's Division of Cancer Prevention and Control (DCPC) as far back as October 1991.
- ♦ Third, an overview analysis of five randomized screening trials conducted in Sweden in the 1970's was reported early in 1993. The study found that the largest reduction of breast cancer mortality, roughly one-third, was observed among women aged 50-69 at randomization. Among women aged 40-49 at randomization, no statistically significant difference was observed.

I would like now to briefly discuss the process by which NCI came to the specific change under discussion today, but before doing so, I want to put to rest the concern that the NCI's position is influenced by political considerations or expediency.

This process was, in one way, initiated in 1991. It was obvious that there was a need to evaluate the new information in the context of the large body of evidence which had evolved since the landmark Health Insurance Plan (HIP) study of thirty years ago. Following a pre-publication, closed briefing in the Fall of 1991 on the Canadian mammography study, NCI began planning a major international workshop of breast cancer screening that was held in February 1993. Many of the scientists who performed the studies, as well as researchers in breast cancer screening fields, participated in this workshop. Results from all eight published randomized clinical trials of screening mammography were reviewed. At that workshop an overview analysis, a meta-analysis, was presented by New Zealand investigators of all the randomized screening trials in the world. This analysis raised questions regarding the benefit of screening women between the ages of 40-49. This workshop was open to both the press and the public. At that time, NCI provided information and resources to the media, interested voluntary, advocacy and health professional organizations, and the public, on the mammography screening studies that were being reviewed.

The final report of the workshop concluded:

- ♦ First, "The randomized trials of women ages 40-49 are consistent in showing no statistically significant benefit in mortality after 10-12 years of follow-up. For this age group, it is clear that in the first 5-7 years there is no reduction in mortality from breast cancer that can be attributed to screening. There is an uncertain and, if present, marginal reduction in mortality at about 10-12 years. Only one study provides information on long-term effects beyond 12 years, and more information is needed."
- ♦ Second, "For women ages 50-69, the evidence presented at the Workshop strengthens the scientific observation that screening leads to reduced breast cancer mortality. Every study presented found a protective effect for women in this age group. The Swedish studies suggest that a screening mammogram as infrequent as every 33 months reduces breast cancer mortality, at least in a population with a high compliance rate and in a setting with high-quality mammography. These data raise the possibility that a screening interval of every 12 months may not be necessary in this population."
- ♦ Third, "Women in their 70's are a high risk group for breast cancer. The currently available clinical trial data for these women are inadequate to judge the effectiveness of screening because the numbers of women were small, the compliance was poor, and the screening episodes were too few."

The Workshop charge was to critically review and summarize the scientific evidence, not to develop guidelines *per se*. In response to this analysis, NCI staff began the process of reviewing our Working Guidelines in the context of the new information. NCI has a responsibility to provide accurate, clear information to the public-based on scientific

evidence. This information clearly held an important public health message for all women and health care professionals.

Subsequently the following process has taken place:

- ♦ During the period from May through August 1993, the NCI PDQ Editorial Board, consisting of both NIH and non-NIH researchers, reviewed and endorsed Workshop results; the NCI staff developed draft guidelines/recommendations which were reviewed by the NCI Executive Committee; NCI staff also met with the American Cancer Society (ACS) to discuss principles underlying the NCI draft guidelines.
- ♦ In September 1993 the draft guidelines were reviewed and discussed by PHS agencies and selected participants from the February 1993 International Workshop on Breast Cancer Screening; NCI staff met with the ACS Breast Cancer Subcommittee, the National Cancer Advisory Board, and with individual members of the DCPC Board of Scientific Counselors to discuss proposed guidelines.
- ♦ During October 1993, NCI disseminated draft guidelines and other materials to agencies involved in earlier guidelines and voluntary advocacy groups, with a request for written comments and attendance at the then upcoming October 21 meeting of the NCI DCPC Board of Scientific Counselors.
- ♦ On October 21, 1993, the guidelines were reviewed by the DCPC Board of Scientific Counselors, who passed a motion recommending that the existing recommendations for women 50 years and over be maintained, and that for women under age 50 NCI provide a summary of existing evidence and data and suggest that these be discussed with each woman's physician or health care provider. In effect, the Board wanted to present the facts, without the pronouncement of a guideline.
- ♦ On November 22-23, 1993 the National Cancer Advisory Board passed the following motion: "Recognizing that there is controversy on the effectiveness of mammography for women under the age of 50 that calls for more research, the members of the National Cancer Advisory Board recommend that the National Cancer Institute defer action on recommending any changes in breast cancer screening guidelines at this time."
- ♦ On December 3, after careful consideration of the conflicting advice of scientific experts, NCI released the following statement summarizing our position on breast cancer screening:

"There is a general consensus among experts that routine screening every 1 to 2 years with mammography and clinical

breast examination can reduce breast cancer mortality by about one-third for women ages 50 and over.

Experts do not agree on the role of routine screening mammography for women ages 40 to 49. To date, randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50."

The process has been open and candid. We have extended our outreach to many diverse groups, both scientists and consumer advocates. We have heard from women's advocacy groups who strongly oppose the use of routine mammography in women under 50 and those who with equal force hold the opposite view. NCI has been intensively reviewing the state of the science regarding mammography screening efficacy for at least two years. After the Workshop conclusions were clear, NCI conducted surveys and focus groups with women and health care professionals to anticipate issues which might help to prepare health professionals and the public for such changes.

Results from the surveys and focus groups indicated that women clearly understand that scientific debate on health issues is sometimes unavoidable.

The NCI maintains communication with many voluntary, advocacy and health professional organizations in the areas of cancer prevention, early detection, and treatment. NCI has redoubled its efforts to stay in close communication with these organizations and to assist where possible in minimizing the confusion that often occurs when recommendations change. And yet, we sometimes must differ even while we may at the same time respect and admire those who disagree with us.

On December 3, 1993, NCI released the new mammography statement and simultaneously communicated with all its own units including the Cancer Information Service--which answers inquiries via the toll-free 1-800-4-Cancer telephone number, the National Black Leadership Initiative on Cancer, the National Hispanic Leadership Initiative on Cancer, the Appalachian Leadership Initiative on Cancer; the Cancer Centers Public Affairs Network; and the Centers for Disease Control and Prevention to determine the strategies and tools needed to convey NCI's breast cancer screening messages in light of the latest scientific review. NCI immediately began updating its own publications and developing a consumer brochure that explains the new position on breast cancer screening for women 40 and over.

The NCI Division of Cancer Prevention and Control is planning a meeting of organizations within the Public Health Service to determine how best to work together on this issue and to organize an ad hoc committee of NCI staff as a first step to develop effective strategies to educate physicians and other health care providers on the new NCI mammography statement.

Perhaps most importantly, NCI staff will continue to meet with breast cancer advocacy groups and voluntary organizations, such as the American Cancer Society (ACS), to clarify issues, identify common ground--and there is common ground--foster cooperation, and explore joint communication efforts, where this is possible.

Mr. Chairman, I welcome your interest and the interest of this Committee and the Congress in this issue. Please allow me to repeat myself: Each of us has a role to play in this enormously important effort to save the lives of American women. This dialogue on mammography is part of the effort. NCI must generate and assess knowledge and then assist in translation of scientific knowledge into the care given at the community level. Science is not separate from life, it is our effort to understand life. NCI's recommendations must be based on scientific evidence to the greatest extent possible, and they must change as new information becomes available. Thank you, Mr. Chairman, for this opportunity to testify. I would be pleased to answer any questions you or other members of the committee may have.

Mr. WAXMAN. Dr. Feder, you describe in your testimony how the President's plan will affect poor women, and you note that women are more likely to be poor and less likely to be employed and privately insured than men. Are you concerned that the cost-sharing requirements of the plan will act as a disincentive for women getting services and are you concerned that the limited subsidies in the plan for low-income Americans will mean that disproportionate number of women end up in low-cost HMO's that provide fewer services than the fee-for-service plans that cost more?

Ms. FEDER. Mr. Chairman, you and I have talked several times about the cost-sharing provisions in the bill, and I guess I would like to reiterate that we believe that we are making a dramatic step forward in bringing low-income people who are not on Medicaid—or who are on Medicaid, regardless—into mainstream medical care for the first time. That in terms of the service—

Mr. WAXMAN. Obviously, those who are uninsured have a clear disincentive to get any care. Now, these women are going to be insured, but I am wondering whether the cost-sharing that they will have to come up with will be a disincentive for them to take advantage of some of these services, especially when we want to give an emphasis on prevention and primary care.

Ms. FEDER. That is one of the reasons we have included the screening services as free.

With regard to the other cost-sharing, you know that we have worked to keep it as low as possible. We know that you have concerns about it, and we will continue to work with you on it.

Mr. WAXMAN. I know that there is some confusion about the plan in its early stages, and I would like to ask you to clarify one point about general women's health for the record.

As you certainly know, many women have an OB-GYN as their major, sometimes only, provider of health care services. Under the President's plan are OB-GYN's considered to be primary care doctors? Will a woman be able to choose another OB-GYN? Will a woman in a managed-care plan in which her OB-GYN does not participate be able to choose to continue to see the same doctor?

Ms. FEDER. There has been some confusion. The relevance of that label, the primary care label in the bill, is only with respect to the defining of residency positions.

The answer to your other question—and in that regard they are defined as primary care physicians.

In regard to your other questions, the answer is, yes, a woman, as a man, can choose their own doctor, whatever the specialty they wish.

Mr. WAXMAN. You did not address in your testimony but I know that this issue has come up and let's get it very clear on the record. Does the President's plan cover abortion services?

Ms. FEDER. Mr. Chairman, on abortion or any other service, the plan covers every medically necessary or appropriate service with the determination of that service being the decision of the woman and the physician or the patient and the physician.

Mr. WAXMAN. Does the President's plan pay for prescription and nonprescription drugs and devices for family planning?

Ms. FEDER. We pay for FDA-approved prescription drugs and for medical devices, not nonprescription drugs or devices.

Mr. WAXMAN. Currently, if a low-income woman is under Medicaid, she would not pay any cost-sharing for her family planning services and States may cover over-the-counter contraceptives. Are the family planning analysts at HHS concerned that the significant cost-sharing of prescription contraceptives and the lack of coverage of nonprescription contraceptives will be a disincentive for women to use family planning?

Ms. FEDER. Mr. Chairman, this goes back to the cost-sharing issue. Again, we generally believe that our provisions provide the protections we need.

We also are committed, as you know, to the continued support for clinics that are providing these services and believe that the combination of provisions has provided the protection that is needed.

Mr. WAXMAN. These title X clinics you are presuming will still be there. Of course, there is a 5-year deadline for them to be guaranteed essential community provider status and a funding stream on that basis. What might happen after 5 years if these clinics are not around?

Ms. FEDER. Essentially, as you know, the purpose of having the essential community providers designated for 5 years is to ensure access to providers who are currently providing important services to women and that provision continues as long as access to those services is needed.

Mr. WAXMAN. And, of course, those clinics will have a tremendous influx of women who were under Medicaid before but now, because of the cost-sharing, may decide that they cannot afford to go through the health plan but go to the clinic, and that is going to be a financial burden on those clinics.

Ms. FEDER. The clinics have also been serving many people without insurance at all and who will have a much broader choice under the President's bill.

Mr. WAXMAN. Thank you very much for my first round.

I want to recognize Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Feder, I would like to address a question to you that focuses on women as caregivers. There has been discussion about that today.

My understanding of the President's proposal, as it applies to the coverage for in-home care and rehabilitative services, makes reference to those services as being required as a result of injury or illness. There has been some lack of clarity as to whether there is coverage for congenital birth defects.

Oftentimes children are born with such serious congenital birth defects that often they need, from the moment they leave the hospital, very intensive in-home care and then rehabilitative services. Is it the administration's view that those services are covered in the basic package?

Ms. FEDER. There has been some confusion, Mr. Greenwood, so I will give it to you in steps.

First, let me be very clear that people, regardless of condition, congenital condition or otherwise, are covered for services in the package. There has been some confusion on this point.

When it comes to the rehabilitative services, some of the post-hospital services, those are benefits that are typically associated, as they are in insurance plans today, associated with an acute episode of illness. There are many plans that do not even have this post-hospital coverage. We have included it, though, with some limitations. We did not intend to exclude a population, and we are happy to work with you to be very clear about that, while recognizing that it is a somewhat limited benefit.

For more extensive services associated with chronic conditions, which applies to many of those particular children with congenital conditions, we look to our new home- and community-based care program to provide those extended services along with some other provisions of the act.

Mr. GREENWOOD. I appreciate that and look forward to working with you on that. I think many policies in the private sector, private market, now are fairly light when it comes to those coverages. There are children, and I have personal experience with this, who are born that need 24-hour a day nursing care, apnea monitors, et cetera, and it is very difficult to find adequate coverage for that, and it is probably for many people the most critical need for health care they may ever experience.

Let me turn to another subject. I had in my office yesterday an advocate from my State of Pennsylvania who represents providers of drug and alcohol treatment, and she argues that the administration's proposal provides less in coverage in the basic package for drug and alcohol treatment than is already provided by statute in 43 States. My question is: do you agree with that statement? Has the task force or the administration surveyed the States to see how the minimum package stacks up against what is already required in the States?

Ms. FEDER. Mr. Greenwood, I would want to double-check on that specific argument or claim. Our understanding is that the policy we are offering is similar to and in many respects better than policies that are typically available today.

You know that the bill commits to a comprehensive mental health and substance abuse benefit in 2002, that we felt it necessary to allow time for the infrastructure to develop, for the capacity to manage the benefits to develop in order to keep our package within affordable bounds, and it is for that reason we have imposed some limitations on days in the hospital or visits under the initial benefit.

But, even in that initial benefit, we offer access to multiple settings of care that is not included in many of today's policies, and we believe that is a significant step forward.

Mr. GREENWOOD. Thank you. I have one additional question. You were present for all of the previous discussion that centered on the abortion issue. Given what is in the bill and given, for instance, the vote on the Hyde Amendment and given the fervor of the opposition that you heard this morning, my question is, what is the administration's strategy to overcome this objection to the package and do you find the possibility for some consensus or common ground in either—the scenario I described?

And I think you were listening when I asked the question as to whether it would be possible for individuals to opt out from cov-

erage as a matter of conscientious objectors. Does the administration have a plan to deal with this issue?

Ms. FEDER. The administration looks forward to working with Members of Congress and working with all controversial issues to get this bill passed and get Americans the security of coverage that they need.

With respect to the specific proposal that you put forward, I was interested in your discussion because I think some of the concerns that might arise were revealed in it. We have put forward a package of benefits that we believe ought to be guaranteed to all Americans. When one starts picking apart pieces—you raised the abortion services, the follow-up was on maternity services, you can see the potential for a coming apart of what is a pool. This is a concern that I think that would arise with that approach, but we look forward to continuing to work with you.

Mr. GREENWOOD. Hoping we can avoid an all-or-nothing scenario there.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman, and thank all of our witnesses.

Let me talk about the mammography issue for a moment, because we heard from the women earlier, and if you look at the new recommendations on the frequency of mammography, and particularly you go into it without some of the further analysis, you say, shoot, these recommendations look like a cost saver. That is really what is going on here, making some recommendations to save some money.

Now, I very much want you to give us some testimony that shows otherwise and that shows that in some way this is related to the science. And let me start by saying the NCI did not follow the Cancer Advisory Board in this case which recommended no changes in earlier guidelines. Is that correct, Dr. Broder?

Mr. BRODER. That is correct.

Mr. WYDEN. How many times has NCI, in effect, overruled the advisory board?

Mr. BRODER. Well, I will come specifically and give you an answer, but I think it is important to stress that there is more than one advisory board involved here. The science-based advisory board, which is the Division of Cancer Prevention and Control, Board of Scientific Counselors, enthusiastically supports the gist and the substance of where we are going and including the new fact statements that have been made, and, in fact, they were part of the process and much of the information that we are now dealing with is part of that process.

The National Cancer Advisory Board is yet a different advisory board. It normally does not get into these kinds of specific issues, but in this particular case it did. The answer is it is uncommon but not zero, and there are periodic times when the National Cancer Advisory Board will make a recommendation that we feel is not consistent with the facts or with the realities of what we have to do under our authorities, and we simply cannot adhere to them. In this case we believe that the facts and the science of it provided an important rationale for proceeding.

The larger question that you are asking is what did the National Cancer Advisory Board mean when they said what they said. And it is important that you recognize that when you put 10 scientists in a room sometimes you will get 12 opinions, and that, in fact, is what I think one of the issues is.

The Chair of the National Cancer Advisory Board, the chairman, Dr. Paul Calabresi, said—and I am quoting from a document after the vote was taken—said, “I am extremely pleased by the nature and substance of the National Cancer Institute’s statements. I think the recommendations are both accurate and appropriate. NCI is a science-based organization, and the statement represents an excellent summary of scientific fact.”

This is from the Chair of that body. In addition, Dr. Howard Temin also wrote in to agree. And what I am saying is that, even during this particular process, there is a divergence of opinion, there is a polarization of views, different people mean different things when they take a vote. That may come as a shock to Members of Congress, but that process does apply in any voting process.

I want to say just one thing. There is no political imperative or momentum to what we are doing. This process has been slow and deliberative and was started in 1991. We are inexorably trying to follow what the facts are leading us to do. We have no choice. I cannot nor can a doctor deal with facts as he or she would want them to be. We will not help anybody that way. And I can’t make things come out the way I want them to come out. It does not usually work out that way. So we have to adhere to the facts.

The process of this started in a closed session of one of our advisory groups in 1991 when certain, as-then-unpublished data strongly suggested that we would have to rethink our position and then followed a process leading to a workshop in February of 1993 where all of these issues were discussed and hashed out and so on.

And so the process has been an orderly one that antedated any of the issues than we are now talking about, certainly antedated the Health Security Act or even the whole concept of what we are now dealing with. I think we can document that, and that is documented in the written comments which I gave to you.

Mr. WYDEN. For the record, if a woman over 50 gets a mammogram every 2 years does she have to pay cost-sharing?

Ms. FEDER. In terms—if she gets it every 2 years and that is what is covered as a screen over 50 so there is no cost-sharing on the every 2 years.

Mr. WYDEN. If a woman over 50 gets a mammogram every year does she have to pay any cost-sharing?

Ms. FEDER. There would be cost-sharing if she had it more frequently unless it were done for—she were identified as being in a high-risk group where there could be a more frequent schedule. But if it were done for diagnostic purposes, there would be cost-sharing.

Mr. WYDEN. Dr. Broder, the NCI statement is—there are measurable lifesaving statements for mammography every 1 to 2 years, is that correct?

Mr. BRODER. No. The statement is this: A general consensus among experts is that routine screening every 1 to 2 years with

mammography and clinical breast exam can reduce breast mortalities by about $\frac{1}{3}$ for women ages 50 and over.

Now, the statement is our best attempt to provide a factual summation. That is, we are trying to do two things. We are trying to get what we think is a fair summary of the scientific consensus and also try to have the issue properly reflect the status of clinical trials.

This also is very similar to the fact statement that came out from the Preventive Health Services Task Force of the Public Health Service again in the late 1980's. And what this basically means is that you can find in the literature randomized, controlled trials which tested the various intervals of mammography as a screening tool in women over 50. You can find clinical trials with randomization that went at 1-year intervals, that went in some cases at 18-month intervals, that went at 2-year intervals. And each of those trials seems to have given us a comparable result.

Now, there are no trials that I am aware of that tested 1 year versus 18 months or 1 year versus 2, but, from a population basis, they gave us approximately the same result, which is in women over age 50 there is about a $\frac{1}{3}$ reduction in deaths. Our statisticians have pored over this, and we feel this is an accurate statement. We can defend this to women. The facts are this way, and we can find clinical trials to support this statement.

Mr. WYDEN. My time is up, but the Chair said I could finish with one last one.

Doctor, does the NCI believe there is some lifesaving benefit in getting more than a mammogram every 24 months or is it that NCI cannot tell whether the statistically significant saving of life happens at month 12 or month 24?

Mr. BRODER. We know a statistically significant benefit occurs. We cannot say that it is due to 1 year versus 2 years.

Mr. WYDEN. Mr. Chairman, my time is up.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Hastert?

Mr. HASTERT. Thank you, Mr. Chairman.

Again greet Dr. Feder and others before us. I have a couple of questions.

Going back to the choice of a physician. Now, if the health care plan that you choose does not have your OB-GYN in it, then I understand you have just said you can go out and use a fee-for-service option to see your doctor. Is that correct?

Ms. FEDER. Remember, we are moving to having individuals rather than employers choose. So we are increasing choice in the plan, and an individual makes a choice of plan. And they can choose—if they choose a plan that has a network, that plan also has what we call a point-of-service option, so that they can go outside the network if they wish.

Mr. HASTERT. And purchase a fee-for-service type plan?

Ms. FEDER. Yes.

Mr. HASTERT. But let's take that one step further. I understand if a fee-for-service plan costs more than 20 percent of the average cost of a regular plan, that fee-for-service plan ceases to exist. Is that correct?

Ms. FEDER. What the bill says—you are referring to a provision that says that alliances—the only circumstance in which they could say that a plan would not be offered in a community could be where premiums exceed 20 percent of the average. That is not a particular kind of plan. That is just a general rule.

Mr. HASTERT. But more typically that provision would impact fee-for-service plans.

Ms. FEDER. All plans will be operating differently under this system.

Mr. HASTERT. But in the situation I described, fee-for-service plans could disappear.

Ms. FEDER. No, the plan essentially—actually, there are special provisions to ensure the continued availability of the fee-for-service plan. So there may be many—what the bill assumes is that there might be more than one or many fee-for-service plans, and it is possible that some of those, like some other plans, could have premiums that exceed 20 percent and then not participate. But there is a guaranteed availability of the fee-for-service plan and, also—let me be clear what I was describing.

Mr. HASTERT. I wish you would.

Ms. FEDER. I am trying to. Essentially, even in a plan that is a network plan, that has a network of providers, that an individual can go out of that network. That is not the same as a fee-for-service plan. They are part of a network plan. They can go out of the network for a service.

Mr. HASTERT. Into another plan?

Ms. FEDER. Essentially the way a plan is likely to work that has a network is it would identify a set of providers and that if you use those providers you have reduced cost-sharing. If you choose to use a provider that is not so identified, then you would have the cost-sharing that is similar to what exists in the fee-for-service plan.

Mr. HASTERT. So there would be an initial fee to do that.

Ms. FEDER. On a visit it would be a 20 percent instead of \$10.

Mr. HASTERT. I think that is fairly clear.

Ms. FEDER. Good.

Mr. HASTERT. I hope. But you also talked about free screening for mammograms and cervical cancer and ovarian cancer. And that is free, right?

Ms. FEDER. That is right.

Mr. HASTERT. Is there a parity? I mean, for instance, for males, is there screening for testicular cancer or prostate cancer?

Ms. FEDER. The services that are provided—we have a number of preventive services that are available with no cost-sharing. They include services that apply to men, women and children. And the selection of those was based on the scientific evidence, some of which you have heard Dr. Broder describe. Though the specific services are those for which the scientific evidence supports screening that is free.

Mr. HASTERT. What is the answer to my question?

Ms. FEDER. On that specific I don't think those conditions—that the evidence is so supportive or that it supports having taken that position.

Mr. HASTERT. In a number of comments, both by the President and First Lady, made to a variety of press and other audiences re-

garding the whole development in the last year of this plan, there definitely seems to be some misperception about what exactly is in the Clinton plan related to abortion services. And I think people are confused about the actual impact of the so-called conscience clause.

And it appears that the President and Mrs. Clinton have left people with the impression that the conscience clause solves the problem of people who do not wish to be associated with abortion.

The actual language of this clause is found on page 95 of the Clinton bill and states, a health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of religious belief.

Now the President has talked about wanting to make abortions safe and legal in his campaign, but rare. And I think this kind of goes along with that—or if somebody has a moral conviction against it. It is my understanding this clause would permit a Catholic hospital to refuse to perform an abortion, is that correct?

Ms. FEDER. That would be my understanding, yes.

Mr. HASTERT. Is it also correct then or incorrect that, under the Clinton bill, that same Catholic hospital that would not have to perform abortions—would have to contribute to a health insurance plan for its employees that does cover abortions?

Ms. FEDER. All employers are expected to make contributions.

Mr. HASTERT. Could they purchase an insurance plan that does not cover abortions in its policies?

Ms. FEDER. All health plans are required to deliver medically necessary or appropriate services and make them available to enrollees.

Mr. HASTERT. Including abortions?

Ms. FEDER. As a medically necessary or appropriate service.

Mr. HASTERT. Is it correct under the Clinton plan the conscience clause would not apply to health plans so that no individual would be able to purchase health care insurance that did not cover abortions?

Ms. FEDER. The purpose—we talked earlier about choice and making certain that consumers are aware of their choices, and that is the reason for our provisions, not the one you stated.

Mr. HASTERT. Could a State prohibit abortion coverage as several do now?

Ms. FEDER. Essentially the plan—when we talked about medically necessary or appropriate services we are also talking about all legal services. So it is coverage that is defined as legal.

Mr. HASTERT. So it does preempt all State law that now exists.

Ms. FEDER. State laws that place some limits on abortion which are legal are constitutional, would continue to apply.

Mr. HASTERT. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Hastert.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by saying first, Dr. Blumenthal, congratulations on your recent appointment.

Ms. BLUMENTHAL. Thank you very much, Congressman.

Mr. TOWNS. Dr. Broder, to this day I fail to understand how NCI can change its mammography screening guidelines when I recall very vividly when Dr. Edward Sondick testified on behalf of your Institute at a subcommittee hearing last fall and confirmed my suspicions that NCI, NIH and even this subcommittee still cannot say with any certainty that mammograms do not save the lives of American women.

Dr. Sondick testified, and let me quote, "But in terms of your basic question, have we learned anything about the role of mammography in reducing the mortality of American women from a study that was conducted in this country? No, we have not, since the health insurance plan of New York study." End of quotation.

I may add it conducted in the 1970's, early 1970's, more than 20 years ago, which means that the technology of that day has changed. I simply cannot comprehend how NCI can support denying women under 50 coverage of mammography when the last study on American women was over 20 years ago. How do you come to a conclusion to make the change without any kind of further study?

Mr. BRODER. Well, thank you for the question.

I think there are several issues. One, the Health Insurance Plan study, which you described, the so-called HIP study, is considered the holy grail of studies. It was, in fact, conducted in part by Dr. Sam Shapiro and others who are considered the real pioneers in this field. That study convincingly showed that mammography would cause approximately a $\frac{1}{3}$ reduction in the death rate for women enrolled in that study. And that became the gold standard and that became the basis upon which a number of recommendations were made and that became the process by which individuals started education programs or related issues.

That study, the approximately $\frac{1}{3}$ reduction in breast cancer mortality rate, has never been surpassed by any subsequent study. That study yielded the best result. No matter what change of equipment, no matter what change in time, no matter what the issues are, as a practical matter that study has yielded the best results. So I believe that it is relevant and important.

It turns out from the best scientific evidence that we can get, that—and the consensus that we achieved or that I think we achieved among the peer groups that were brought into the workshop in February of 1993—that the benefits of mammography were primarily due to the benefits that occurred in women over the age of 50 and that for women between the ages of 40 and 50, there was no statistically significant benefit that one could derive from the HIP study.

And, in addition, from approximately eight other studies conducted in multiple parts of the world, pooling those studies together at a metanalysis, there is one monotonous answer that seems to occur as a practical matter. What is interesting is that the same answer seems to be coming out. In women over the age of 50, virtually all of these studies and virtually all of the scientists involved in conducting those studies get the same answer. Mammography reduces the death rate by about a third, roughly. Between 40 and 50 there are no statistically significant data to suggest that we can have a reduction in the death rate.

So that is a fact, and we do not know how to avoid that fact. We have to say that fact. Even if somebody said I want to offer women mammography screening between ages 40 and 50 because I think it is the right thing to do, in our opinion that individual who said that—who offers that—has to at the same time tell women what the results are and what the scientific consensus is where there is one.

And what we are saying is there is a general consensus for women over the age of 50 that mammography works to reduce the death rate. What we are saying is there is no such consensus, there is deep and divided polarization, for women between the ages over 40 to 49 and to indicate randomized clinical trials simply have not shown that. That is our statement.

Now, we do not know how we would respond to a woman who asked us what is the basis upon which you are making a recommendation, unless we stick to the facts in the clinical trials as we have them. So that would be my response.

There is also another comment that you started with, which I just need to clarify. We at NCI do not feel we are giving or denying medical care to women. We are not in the reimbursement business. We have to stick to the facts, and we cannot make and do not wish to make reimbursement policy. We have to stick to the facts. And the process that we talked about today started, in effect, in 1991 when a study done in Canada did not show a value for mammography reducing the death rate in women between the ages between 40 and 50.

You quoted Dr. Sondick. He is in the audience.

Mr. TOWNS. I see him with the nice tie on.

Mr. BRODER. If the Chair will permit and time permits, if I have not said things correctly Dr. Sondick can run circles around me statistically and knows all sorts of things that I certainly do not know. If the Chair will permit him to come to the table to answer this question or we can respond in writing or whatever.

Mr. TOWNS. My time has expired so you can respond in writing.

Mr. BRODER. I appreciate the question. We will be happy to provide follow-up. But there were other issues as well, such as false positive and false negative rates and so on. But we will be happy to respond in writing.

[The information follows:]

In response to your question, Representative Towns, please allow me to reiterate this point. In 1987, the NCI developed Working Guidelines for the early detection of breast cancers. These guidelines provided the American public with a summary of the state of knowledge at the time. They were made in order to crystallize the best thinking at the time, but with the understanding that if crucial new information became available, the guidelines would be modified. As it turns out, for the population in whom the vast majority of breast cancer (women over age 50) is found, the recommendation is still basically correct. Thus, to a large extent, these 1987 guidelines were the right thing to do in that 80 percent of breast cancer cases occur in women over age 50. The NCI did not make a mistake then, and we do not believe we are making a mistake now. (1)

At the time these guidelines were developed, evidence for screening was strongest in women ages 50-69, although the Health Insurance Plan of Greater New York clinical trial had shown a reduction in cancer deaths for all ages mixed together due to screening in this study of 60,000 women aged 40 to 64 at the inception of the study.

The Health Insurance Plan of Greater New York was a landmark randomized clinical trial on mammography and clinical examination. In 1963, the HIP study

began to enroll 60,000 women from the ages of 40 to 65 who had been HIP members for at least a year. About 30,000 were given screening and clinical examination while a comparable number of women were not offered screening and were asked to follow their usual medical practices, which, at the time, would not have included screening mammography as a general rule. The study took several years to accrue enough patients. Follow-up extended for about 18 years. The overall reduction in deaths due to screening in this study was largely due to the impact on women over 50 years of age. There was a contrast between the older and younger groups, with mammography appearing less useful in the younger women in the HIP study, but more information was needed. And there was a uniform hope that mammography would be found to work in all age groups.

In short, even this intensive and extensive trial needed subsequent studies to allow for more precision and accuracy in information about screening. Some researchers would have been willing to wait for more trials without acting. Yet many scientists, including those at NCI, believed that the HIP study provided enough information to initiate screening practices while at the same time conducting research to seek more information.

Even then, several non-governmental and governmental groups (such as the American College of Physicians and the U.S. Preventive Services Task Force) opted not to go along with these guidelines and did not recommend screening mammography in women under age 50. NCI considered the above guidelines to be working guidelines with the clear intent to revisit them should any new information become available. Many experts feel that the time for revisiting them has come.

We believe this was the right course of action. We did our homework. We did confirmatory analysis (such as applying the case-fatality methodology to the HIP study and analyzing various demonstration projects), and we recommended mammography for a wide age group, including women over age 40. One of the most important programs of the 1970's was the Breast Cancer Detection Demonstration Project (BCDDP), cosponsored by NCI and the American Cancer Society (ACS). To show how complex the history of this topic really is: in the spring of 1977 the project's directors and advisors recommended restricting the routine use of mammography in those women under age 50 with no family history, in part because of concerns in that era over radiation doses. Thus, for various reasons and at various times, the NCI has modified its recommendations for younger women.

For a period of time, there were rapid improvements in the quality of mammography and access to such screening, and hopes were high that all tumors could be found at an early stage and that finding such tumors would lead to more cures. During this time, a number of brave women who were in the public eye spoke candidly about their disease; as a result, breast cancer was more discussed and more understood and women and their doctors were seeking answers.

Certain clinical studies continued, including a major randomized trial in Canada, for which many physicians and patients alike had high expectations. And yet, there were concerns even then that, in some young women, certain tumors could be invisible on conventional mammography screening, sometimes even when the tumor was palpable on clinical examination. And as our knowledge of the biology of breast cancer grew, there were also concerns that some tumors may shed microscopic deposits of cancer cells into distant parts of the body even when the tumors are exceedingly tiny and undetectable with our present technology, and it is those cells that have spread, not the primary tumor, that ultimately kill women as a general rule. This fact that some tiny tumors can metastasize quickly confounds the prophecy that if a tumor can be detected very quickly, the patient can be cured. Early detection in many types of cancer certainly makes sense, and we should vigorously pursue early detection whenever the scientific facts support it. Yet, in some women, it is a tragic fact that the biology of their cancer determines their fate from the earliest moments. In such cases, survival may be determined by whether a woman receives state-of-the-art therapy (including adjuvant chemotherapy) once a tumor is found.

NCI has been intensively reviewing the state of the science regarding mammography screening efficacy for at least 2 years with a keen awareness of how important, indeed, how awesome, was our task. After the Workshop conclusions were clear, i.e. that screening reduces breast cancer deaths for women ages 50-69, but for women 40-49 the data had not shown a reduction in mortality, NCI conducted surveys and focus groups with women and health care professionals to anticipate issues that might help to prepare health professionals and the public for such changes.

Results from the surveys and focus groups indicated women clearly understand that scientific debate on health issues is sometimes unavoidable. They do not want to be artificially shielded from such debate. The actual decisions about mammography will need to be made by an individual woman in a dialogue with her health care provider after she weighs and considers the pros and cons. Our focus groups

suggest that some younger women will continue to ask their doctors for mammograms. If facts inform the decision, we will have done our job.

The NCI maintains communication with many voluntary, advocacy, and health professional organizations in the areas of cancer prevention, early detection, and treatment. NCI has redoubled its efforts to stay in close communication with these organizations and to assist, when possible, in minimizing the confusion that often occurs when scientists revisit a situation. Yet, we sometimes must differ even while we may, at the same time, respect and admire those who disagree with us.

(1) 1987 guidelines

—The screening process should begin by age forty and consist of annual clinical examination with screening mammography performed at 1 to 2 year intervals.

—Beginning at age fifty both clinical examination and mammography should be performed on an annual basis.

—Physicians should encourage women to perform monthly breast self-examinations.

Mr. WAXMAN. We are going to have a second round so maybe some of these issues will still come up.

Just to get all these things on the record. A free mammogram every 2 years is not the same as a free mammogram every 1 to 2 years. Dr. Feder, why did the administration choose to limit the benefit to once every 2 years and not every 1 to 2 years?

Ms. FEDER. Mr. Chairman, when we looked at what benefits to specify that would be free, without any regard to cost-sharing, we looked at the scientific evidence. As you have heard from Dr. Broder, when we found no difference in terms of those frequencies, whether it was 1 year or 2 years, we took—we thought 2 years was the appropriate interval taking the more conservative approach.

Mr. WAXMAN. Do you believe that low-income women will find that—cost-sharing and deductibles in the President's plan to be a deterrent to getting mammography services that are not free?

Ms. FEDER. We believe that, essentially, we are including them in plans in which necessary and appropriate services, must be delivered. We have to hold those plans accountable and so we believe we are making dramatic improvements for all women.

Mr. WAXMAN. Dr. Broder, in your professional judgment is this a problem? In other words, do you believe there will be statistically significant excess mortality from breast cancer because low-income women only get mammograms every 2 years and not every 1 to 2 years?

Mr. BRODER. No. And I also think we will have a sea change of providing and conferring the benefits of technology to women who otherwise do not get such technology.

Mr. WAXMAN. If a woman over 40 and 49 gets a mammogram every 2 years does she have to pay any cost-sharing?

Ms. FEDER. That is not a screening service. That is correct. She would pay cost-sharing. That is a function of the plan she chooses.

Mr. WAXMAN. And do you believe, again, that low-income women will find the cost-sharing and deductibles of the President's plan to be a deterrent to getting mammography services that are not free?

Ms. FEDER. I would reiterate what I said earlier, Mr. Chairman. I think that we have to hold health plans accountable for delivering appropriate services and work to achieve that goal.

Mr. WAXMAN. Dr. Broder, in your professional judgment should low-income women who decide with their doctors they should get a mammogram have any disincentive for getting such services because of cost-sharing?

Mr. BRODER. You are asking for my professional judgment?

Mr. WAXMAN. Yes.

Mr. BRODER. Speaking only for myself, I don't believe that economic factors should be in the mix. I think that a doctor and a woman, her health care provider, should be able to sit down and deal with the science, what is best for her in her situation. She should know the science. The doctor should not attempt or the health care provider should not attempt to short circuit that. I think there has to be a full and open discussion.

But speaking for myself I don't believe that the economics of it should be the factor that decides.

Mr. WAXMAN. Dr. Broder, assume you have a patient who is a woman 45 years old. She has no symptoms of breast cancer. She has no family history of breast cancer. She has no known risks for breast cancer. She has read about breast cancer, is concerned about whether to get a mammogram. In your professional judgment would you recommend that this patient have a mammogram every 2 years?

Mr. BRODER. This is a woman over the age of 50?

Mr. WAXMAN. 45.

Mr. BRODER. I think I would answer that two ways. I think that many—speaking only for myself, I believe in the sanctity, if you will, of a doctor-patient relationship, and I believe that has to exist and has to be uninhibited. I believe that I cannot, sitting here inside the beltway, make those kinds of judgments and interpose myself into ongoing doctor-patient relationships.

I would say, however, that—to keep the discussion focused on what we are saying today—it would be wrong for the health care provider to attempt to induce the woman to obtain mammography or to say the basis of the decision, whatever it might be, is informed by the fact that mammography in that age group has been shown to save lives.

In other words, there is a duty for the health care provider to give a full disclosure of the science as best as one knows it and then to allow an informed process to go on. The patient as a consumer is part of the process. She is not just on the receiving end of divine wisdom. A patient has to participate in that process. But the facts have to be clear. So I would object if a doctor said I am going to ask for a mammogram because it has been proven to work in your situation.

I also think the doctor would have a duty to discuss things such as the false-negative rate, the false-positive rate, the probability or the possibility that there might be an unnecessary biopsy or other procedures and what exactly does it mean to undergo a program of screening mammography in that age group and to give a fair and informed consent on that process.

Mr. WAXMAN. Well, after you have gone through all of that, analysis of the statistics and all of the relating ramifications, she turns to you and said, Dr. Broder, what should I do?

Mr. BRODER. I don't mean to evade your question, but I cannot answer it in the abstract. Each doctor-patient relationship would be different. There are a number of factors that might be informing that woman's concerns.

I would also go further. Sometimes—this is an area that I can defend and, having given a long lecture about science and the scientific method, I will contradict myself. I believe sometimes patients know things about themselves—I am a strong believer in that—even if they cannot articulate it. I believe the patient or consumer is sometimes the best person to know that something is wrong, even if they cannot bring it to consciousness. Occasionally even if they know that something—they have identified it, for a variety of reasons the man or woman does not choose to bring that to the attention of the doctor. As a physician, I can tell you I have seen that happen and that what the patient is really doing is asking for further inquiry and further questioning.

For example, to counter your theoretical situation, I might in that situation ask a more acute question about is there really a lump there, is there something you are not telling me, however I might phrase it. I might ask a nurse or someone with more sensitivity than me and more rapport to get the elicited history, and it might well be that the woman has a lump inside her breast that she found.

Mr. WAXMAN. Or she is anxious.

Mr. BRODER. Anxious, but anxious on an informed basis.

Mr. WAXMAN. Now, Dr. Feder, under those circumstances if the doctor and the patient decide to have a mammogram should there be cost-sharing?

Ms. FEDER. In those circumstances we regard—that would be for diagnostic purposes, as Dr. Broder is laying out, and they are covered as diagnostic services with the cost-sharing that is in the plan.

Mr. WAXMAN. With cost-sharing.

Ms. FEDER. That is correct.

Mr. BRODER. But speaking as a physician-scientist, the issue of diagnostic—I have to make something clear, and I apologize for taking the time of the committee. If there is a lump, if there is something wrong, if the doctor and the patient are in a situation where there might be something wrong, I don't want to hear from anybody that mammography is not a tool that one would use in the diagnostic evaluation of the practice and art of medicine.

And so I don't know how to say that any clearer than what I have just said. That is a different area. I do not have standing nor do I wish to have standing to tell you about what the reimbursement scheme is or what that part of the equation is. That is not my expertise. But nobody should say mammography is not a useful tool or I have heard things about it. That is a different category altogether from what we are talking about today or at least what I am talking about today.

Ms. FEDER. And it is covered as such.

Mr. WAXMAN. Thank you.

Mr. Wyden.

Mr. WYDEN. One last question on the mammography question, if I could, for you, Dr. Feder.

It seems to me to that for low-income women specifically they are going to find cost-sharing and the deductibles in the President's plan a deterrent to getting mammography services that are not free. Just for purposes of this, what if we got rid of the cost-sharing

and deductibles as it relates to low-income women and maybe we could get your assessment of what it would cost.

Ms. FEDER. First, let me clarify what is there for low-income women. In a low-cost-sharing plan there is no deductible. We are talking about \$10 a visit. So I know we want to be clear, and I know you may still have a concern, but that is the nature of the provision.

I think we would be happy to provide you more information on specific alternatives to the approach we have taken. We took the approach we did because we believe that we are able in this approach to provide access to high quality care in an affordable way.

Mr. WYDEN. I would like that supplied for the record. Because the question for me is this may be a chance for a modest investment to get a significant return. Now, you may have some analysis that would suggest that it would increase volume and the like, but if you would supply that for the record.

Ms. FEDER. Just to be clear, Mr. Wyden, are you asking in general or for specific services, for the mammogram specifically?

Mr. WYDEN. I am talking about mammography services for low-income women. I think that what you heard from a number of panel members is that we are concerned that the cost-sharing and the deductibles will be a deterrent to low-income women. We pummeled the science with Dr. Broder. Let's see if you can give us the cost-sharing.

Ms. FEDER. Be happy to respond.

[The information follows:]

The question is often asked as to whether annual screening is more effective than screening every 2 years.

The eight randomized trials of breast cancer screening conducted to date provide the most extensive evidence about screening efficacy, but do not answer, definitively, all questions that can be posed. A major reason derives from the widely varying ways in which the trials were conducted. For example, the landmark Health Insurance Plan of Greater New York Study (HIP), the first major trial of mammography, tested a regimen of annual mammography and clinical breast examination against a regimen of no annual screening. The successful Two-County study in Sweden, which had results very similar to those of the HIP study in terms of breast cancer mortality reduction, included single view mammography at intervals from 24 to 33 months. Despite these differences both studies achieved similar reductions in deaths.

NCI staff have rank-ordered all the trials according to their screening frequency, and found that each trial achieved about the same level of mortality reduction. In fact, NCI staff were unable to identify from the results of the trials a relationship between how frequently a woman is screened and the extent of mortality reduction. Indeed, all the trials achieved about a $\frac{1}{3}$ reduction in death rates. In his own review of the data, mammography researcher Alan Morrison concluded, "The data are not helpful in choosing a screening interval within the range 12-33 months." [Efficacy of Screening for Breast Cancer in Older Women, *J Gerontology*, 1992, 47:80-4] The NCI statement, issued on December 3, 1993, reflects this scientific fact: The trials show equal reductions in death rates, whether the screening is done annually or every other year.

In order to explore the question even further, NCI staff, as well as breast cancer screening researchers from the Netherlands, have developed computer-based screening models. Using these analytic tools they estimated the possible effects of screening at different frequencies. This type of analysis is essential if we are to design and assess the feasibility of a randomized, controlled clinical trial to study any difference in a prospective manner. Using these models NCI staff estimated that, based on a mortality reduction of 33 percent for annual screening, biennial screening could achieve about 85 percent of that figure or about 28 percent, which would be about a 5 percent difference in breast cancer deaths. However, it must be emphasized that those trials that have shown statistically significant mortality reductions all achieve about the same level of reduction, regardless of whether the screening

was conducted on an annual or a biennial schedule. Clinical trials are the gold standard, and give us results that can be most validly generalized to the population as a whole. All other analyses, including the analytic work of our staff, are subject to various assumptions and methodological issues that limit the extent to which we can draw conclusions.

In summary, based on the trial data, and the analytic work, NCI stated that screening women 50 years of age and over at a regular interval of every 1 to 2 years can reduce breast cancer mortality by about $\frac{1}{3}$. At this time it is not possible to narrow the estimates, or to be more specific about mortality reduction as a function of the frequency of screening.

Mr. WYDEN. One last area, and that is the contraceptive pricing. I think the government is getting ripped off, and we are getting ripped off every single day. We subsidize devices like Norplant, for example, for people overseas. The taxpayer does a lot of the heavy lifting in terms of getting it developed. People cannot get it in this country.

Why couldn't we, within about 60 days, at a minimum, set up a government-wide purchasing group so that the government agencies that are purchasing these drugs that are so critical to women and their families would be in a position to do some hard-nosed bargaining with these drug monopolies and we could get a good price for women, get a lot more contraceptive services out across the country?

I am of the view that could turn around this problem and help a lot of women and families within about 60 days. Am I missing something?

Ms. FEDER. You rarely miss things, Mr. Wyden. I think this is something—you are talking about an existing program and that is something that—I believe that was something that has been discussed at various times with respect to various services that are—drugs that are purchased, and we can continue to explore that with you.

Mr. WYDEN. Look at it, if you would. Let me get your opinion on that. I think, yes, we can turn it around in 60 days even before we get a good bill on the President's desk with many of the features you are including. But why not have it also in the President's health package? That where there are drugs, particularly drugs for vulnerable people, where the taxpayer has done much of the development. Why not have in place the tools for a government-wide purchasing group?

Ms. FEDER. Again, we can explore it further. But you know that in terms of the public purchasing for Medicare that is—the rebate—is included in that provision and that is a related approach, if not exactly the same. So we can continue to explore it.

Mr. WYDEN. But certainly in the area of contraceptives, though, we have to get beyond the Medicare population, and I think you all are on the right track in terms of the smart shopper concepts in terms of Medicare. Medicare in the bill will use its leverage to get a better value. What I am saying is let's make the government a much smarter, much savvier and much more effective bargainer by pooling, for example, with foreign aid programs, Medicaid programs, PHS programs, and then we can really get some value for women.

Ms. FEDER. That would be—again, we continue to look at it. But I would clarify for you that, essentially, with the exception of the—well, for everybody, through insurance—that is being covered

through insurance, which would apply to the population currently on Medicaid as well, that kind of negotiating and bargaining is what is happening in health plans. So that is the structure. That is the way in which that would play out.

Mr. WYDEN. And, again, I think the bargaining that is going on in health plans makes some sense, but we are talking about these big public kinds of programs. We are talking about Medicaid, the PHS programs. We had Wyeth come and make a disgraceful statement saying they would not give a break to low-income women because they were afraid it would alienate the affluent.

If you had a government-wide purchasing group, both in 60 days to deal with the immediate situation and in the bill for the long term, we would never have that happen.

Ms. FEDER. We will continue to explore it with you.

Mr. WYDEN. Thank you.

Mr. WAXMAN. Thank you, Mr. Wyden.

I want to take advantage of the fact that Dr. Blumenthal is here, and she is an expert as a psychiatrist in the mental health area, and those of us who follow this issue know that women have a disproportionate share of mental health problems, especially depression.

Could you tell our committee what the President's proposal would do for women in terms of their emotional and psychological services?

Ms. BLUMENTHAL. Thank you, Congressman Waxman. It is an honor to be here before the committee.

In terms of the mental health benefits provided under the plan, there is a substantial step forward in this regard. For the first time, I think, in terms of most plans, preexisting condition will be eliminated and so will lifetime caps.

As Dr. Feder pointed out, by the year 2002 there is the mandate for comprehensive mental health and substance abuse benefits while we are waiting to develop an infrastructure of services. I think that what we will—what the plan will be providing, though, is unlimited medical management for these conditions, which is, again, a major step forward, in addition to outpatient and, I know, patient hospitalization.

I want to say, too, that I think that there have been irrefutable national statistics that have pointed to a real health crisis for women in this country. We know that women have been treated as second-class citizens both in the delivery of care and access to health care services as well as in the way biomedical research has been conducted.

I think that the plan really does take us a step forward in this in terms of assuring all American women access to quality health services and not only medical services but preventive services at no cost to them that will go a long way, I think, to promoting the health and well-being of women in this country today.

Mr. WAXMAN. Thank you very much. I appreciate that. And we need to look at the perspective of this legislation not just from the point of view of abortion, which is a significant issue, but the whole range of services that are finally going to be available to the women of this country.

I want to thank all of you for your testimony. We will look forward to working with you at a later session.

I would like to call forward our next panel. Dr. Karen Davis is the executive vice president of the Commonwealth Fund. Betty Dooley is the executive director of the Women's Research and Education Institute. And Joan Kurlansky is testifying on behalf of the Campaign for Women's Health. She is the executive director of the Older Women's League, and the covenor of the Campaign for Women's Health.

We are pleased to welcome you to our subcommittee hearing today. Your prepared statements will be in the record in full. We would like to ask you, however, to limit the oral presentation to no more than 5 minutes so we will have a full opportunity for questions and answers and to get through a very long schedule of witnesses.

Dr. Davis, we will hear from you first.

STATEMENTS OF KAREN DAVIS, EXECUTIVE VICE PRESIDENT, THE COMMONWEALTH FUND; BETTY DOOLEY, EXECUTIVE DIRECTOR, WOMEN'S RESEARCH AND EDUCATION INSTITUTE; AND JOAN A. KURLANSKY, CONVENOR, CAMPAIGN FOR WOMEN'S HEALTH

Ms. DAVIS. Thank you, Mr. Chairman and members of the subcommittee.

Health care reform is a woman's health issue, and it is very appropriate that this hearing is being held today. In the interest of time I would like to make some points contained in the charts at the end of my testimony beginning on page 12.

As Congresswoman Snowe indicated in her opening remarks, health insurance coverage is very important to women. They are more likely to be poor, more likely to be dependent upon Medicaid and Medicare, public programs, for health insurance coverage because they are less likely to be working in jobs that provide good health insurance coverage.

On the chart on page 12 I point out this is particularly a problem for minority women. Twenty-two percent of all Hispanic women are uninsured, as are 16 percent of all black women. We know that women are not getting the care that they need.

The next chart in my testimony indicates the results from the Commonwealth Fund National Survey of Women's Health conducted in the spring of 1993. We found that 13 percent of all women report that there were times during the year when they needed care and failed to get it, compared with 9 percent of men. If you look at uninsured women, 36 percent, more than $\frac{1}{3}$, failed to get necessary care at some point during the year.

Another survey we did later in the year with the Kaiser Foundation found that up to 70 percent of the women postponed care because they were unable to afford that care.

Congresswoman Snowe also referred to our women's health survey and its finding, as illustrated in the chart on page 14, that a third of women failed to get preventive services on a regular basis.

For uninsured women it is even higher. Half of all uninsured women fail to get regular Pap smears; 62 percent of all uninsured women over age 50 fail to get an annual mammogram. When we

asked women why they did not get preventive services, cost was the single-most reason, even for insured women. Twenty percent reported mammograms and Pap smears were not covered by their insurance plans.

Women also are in more need of long-term care. Women live longer than men. They are often caregivers for a frail spouse, a frail husband, but when they need long-term care, there is frequently no one available to provide it and they are often living alone. Turning to page 14, even in any given age group, women are more likely to have limitations of activities of daily living, and certainly they are much higher users of both nursing home care and home care services.

On page 16 I note that at the younger ages, between 18 and 44, women use more health services than men—that is mostly related to reproductive health needs, pregnancy—and have higher health expenses, although they are somewhat lower than men in the ages of 45 to 64.

Our women's health survey also looked at the issue of health maintenance organizations. We found that health maintenance organizations typically do provide preventive services, and women are likely to get preventive care. On the other hand, we were concerned to find that women in health maintenance organizations were less likely to rate their physician as excellent or less likely to say their physician listens very well. About a 10 percentage point difference between women in HMO's and those who are not in HMO's.

I want to focus, though, on the President's plan and what it means for women.

The first point of universal coverage is important to women. Women are more likely to be poor, less likely to be employed in jobs that provides them with health insurance, so to be guaranteed coverage and very many the security that they will never lose their coverage even if they change jobs or change marital status or move is very important to women.

The President's plan contains comprehensive benefits that are very important to women, not only the coverage of reproductive health services and preventive services, which we have heard a lot about today, but also the coverage of mental health services that Dr. Blumenthal talked about, since women are disproportionate users of mental health services and prescription drugs.

We found, for example, that women use 18 percent more prescription drugs than men, and in part that can be related to things like hormone therapy or contraceptive drugs, but that is a very important benefit for women.

The long-term care provisions in the President's plan are also very important to women. The home- and community-based benefit would certainly help many women, both those who are caregivers to assist them in caregiving and in providing services to frail women. However, the block grant nature of the home- and community-based benefit could lead to frustration and unmet expectations if there is not sufficient funding to guarantee that the range of services that are to be covered are included.

Insurance market reform is very important for women, particularly women with conditions such as breast cancer, to assure they

can get health insurance coverage, but it is not sufficient by itself to cover all women.

Managed care, I think, raises some concern for women, and I think the points that have been made in the hearing today about the high cost-sharing, the \$400 deductible, 20 percent coinsurance and fee for services is a very important concern for low-income women.

And, finally, that the method of financing the plan through Medicare and Medicaid cuts will be borne disproportionately by women and could form a hardship for them.

Thank you, very much.

Mr. WAXMAN. Thank you very much, Dr. Davis.

[Testimony resumes on p. 130.]

[The prepared statement of Dr. Davis follows:]

WOMEN'S HEALTH AND HEALTH CARE REFORM

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on the critical issue of women's health and health care reform. While health care reform is vitally important for all Americans, it has particular significance for women because they are less likely to get needed health services and are more likely to be financially burdened by health care bills than are men. In addition, women play a major role in making health care decisions for their families.

Today, I will review why health care reform is of central concern to women, drawing on findings from The Commonwealth Fund's national Survey of Women's Health, which was conducted by Louis Harris and Associates in early 1993 and interviewed 2,500 women and 1000 men. My statement will also draw on work of The Commonwealth Fund Commission on Women's Health, a group of national experts analyzing critical issues in women's health. I will conclude with an analysis of the Health Security Act as it affects women, identifying features that would help improve the health of American women as well as concerns it raises.

Health Care Reform is a Women's Issue

Insurance Coverage. Women are slightly less likely than men to be uninsured. In 1992, 16.5 percent of men and 13.1 percent of women were uninsured. This coverage gap between men and women is explained in large part by the fact that women are more likely to be insured through public programs.

More adult women than men, 10 percent versus five percent, were covered by Medicaid in 1992. Eligibility for the program is derived largely by whether individuals receive welfare support through the AFDC program, which primarily serves female single-parents and their children. Additionally, most recent eligibility expansions in the Medicaid program have targeted pregnant women.

Since women live longer than men and comprise a disproportionate share of the elderly population, they are overrepresented by the Medicare program. In 1992, Medicare covered 19.3 million women and 14.3 million men. Considering these coverage patterns, Medicaid and Medicare are of disproportionate interest and concern to women.

Despite the importance of Medicaid coverage, low-income and minority women are at especially high risk of being uninsured. Twenty percent of women with income of \$7,500 and less are uninsured, compared with 5 percent of women with incomes over \$50,000. Twenty-two percent of Hispanic women and 16 percent of African American women are uninsured, compared to 13 percent of white women.

Men are slightly more likely than women to have employment-based coverage. Sixty-one percent of women and 65 percent of men are covered by employer-paid health insurance. However, women's coverage is more likely to be through their spouses' employer rather than their own. Sixty-six percent of working men have coverage through their own employers, compared to 52 percent of working women.

Health Insurance and Access to Care. The link between insurance and access to care is even more critical for women than for men. In 1993, the Commonwealth Fund Survey of

Women's Health found that 13 percent of women compared to 9 percent of men did not get needed care during the past year. For the uninsured, these numbers increase dramatically: 36 percent of uninsured women compared to 23 percent of uninsured men did not get needed care within the year. Also in 1993, a Kaiser/Commonwealth Fund survey of health insurance found that 35 percent of women compared to 24 percent of men postponed needed care during the year.

Access to needed care also varies with different types of insurance, raising the concern that many American men and women are underinsured. Nineteen percent of women on Medicaid did not get needed care during the past year, compared to 10 percent of women with employer-paid insurance, and six percent of women with Medicare coverage. Medicaid's historic low rates of provider payment and low provider participation may help explain the more limited access to needed care for Medicaid beneficiaries.

Lack of a regular source of care and use of the emergency room also vary substantially with insurance coverage. Thirty-five percent of uninsured women lack a regular source of care, compared to 24 percent of Medicaid beneficiaries, 22 percent with self-paid/private insurance, 18 percent with Medicare, and 18 percent with employer-paid insurance. Medicaid beneficiaries are more than twice as likely to use clinics and emergency rooms for regular care, compared to those with employer-based insurance.

Lack of insurance increases the probability that a woman will not receive preventive services. Sixty-two percent of uninsured women over the age of 50 did not have a mammogram in the past year, compared to 44 percent of all women over 50. Fifty percent of uninsured women did not have an annual Pap smear, compared to 35 percent of all

women. Sixty percent of uninsured women did not have a complete physical exam in the past year, compared to 39 percent of all women. Cost is the reason most often cited for not receiving preventive care. Even insured women do not always have coverage for these essential services. Almost twenty percent of insured women reported that they were not covered for preventive services such as mammograms and Pap smears.

Use of Health Care Services. Women, especially younger women, have a greater need for health care services, due in large part to their reproductive needs. Women in general use more mental health services and have more long-term care needs. Eighty-four percent of women and 73 percent of men report seeing a physician in the last year. In 1987, 9.3 percent of women used mental health services, compared to 5.8 percent of men. Among Medicare beneficiaries, women obtained about 18 percent more prescriptions than men during 1987, perhaps because of their greater use of physician services. During childbearing years, women experience more hospital admissions than men. At all other ages, however, men are more frequently hospitalized.

Women's longer life expectancy increases their need for long term care. At age 65, women can expect to live 19 more years, compared to 15 years for men. Older women are much more at risk of being frail and living alone -- increasing the need for long-term care. Forty-eight percent of women who reach age 65 use nursing home care at least once before death, as compared to 28 percent of men. Older women also experience more limitations in activities of daily living than do men of the same age.

Spending on Health Care Services. Total spending for women's health care services, including payments by insurance companies and public programs, exceeds that of men. Much of this spending is due to women's reproductive needs. In 1987, women ages 15-44 spent \$70 billion on health care. Men of the same age spent \$41 billion. At other ages, women's total health expenditures per capita are less than those of men.

Women are more at risk than men for financially burdensome medical bills. Women comprise 51 percent of the population, yet they pay 63 percent of all out-of-pocket personal health expenses. These expenses include the cost of reproductive care, preventive services and prescription drugs. Among Medicare beneficiaries, women spent out-of-pocket an average of 10 percent more on prescription drugs than did men in 1987.

The burden of out-of-pocket expenses falls disproportionately on poor women. In 1987, 12.7 percent of poor women ages 15-44 spent more than 10 percent of their income on health care services, compared to 1.3 percent of middle income and 0.5 percent of high income women.

Managed Care. Women are slightly less likely than men to be members of Health Maintenance Organizations (17 percent versus 21 percent), and their experience with managed care organizations appears to be mixed. On the positive side, women in HMOs report having received selected preventive services such as mammograms at comparable rates to those with employer-based plans and at higher rates than those with self-paid plans, those with public coverage, and the uninsured. Only 15 percent of women in HMOs say that cost caused them to forego preventive services, compared with 31 percent of those not in HMOs.

Additionally, benefit packages of HMOs are more likely to provide preventive care: 95 percent of HMOs include preventive services, compared with 82 percent of Point-of-Service plans, 78 percent of Preferred Provider Organizations and 70 percent of conventional fee-for-service plans.

However, women in HMOs report being less satisfied with their physicians. The Commonwealth Fund Survey of Women's health found that forty-two percent of women HMO members rated their physician as excellent in providing them with good health care overall, compared with 52 percent of non-members. Women in HMOs were also less likely to say that they felt that their physician listens to them "very well" (63 percent of HMOs members, compared to 73 percent non-members).

In summary, health care reform is particularly important for American women because they are less likely than men to get needed health services, more likely to use health services largely because of reproductive and long-term care needs, and more likely to pay higher out-of-pocket costs for care. An analysis of women's insurance coverage patterns, health care needs and costs, confirms that health care reform is a women's issue, which needs careful evaluation from that perspective.

The President's Health Security Plan: Extent to Which it Addresses Women's Health Issues:

Universal Coverage. The central feature of President Clinton's Health Security Act is its commitment to universal coverage for all Americans. This provision could be particularly

important for women, who are more likely than men to be poor and are less likely than men to work full-time and to have employer-paid health insurance. It is clear that lack of health insurance impedes women's access to health care services. The promise of universal and portable coverage to every American woman, regardless of her income, employment status, welfare status, race, or age, could improve her sense of security, access to health care and health status. Low-income, less educated, and minority women could benefit from this provision, since disproportionate percentages of these groups are currently uninsured.

Comprehensive Benefit Package. The Health Security Act would be a significant advance for most women since it offers a comprehensive benefits package that includes primary care services, reproductive services, preventive screening tests, mental health services, and prescription drugs. Medicare benefits under the Health Security Act would be improved, so that beneficiaries would be covered for a new benefit, outpatient prescription drugs. Adding prescription drugs to Medicare would improve financial protection for older women, since they are disproportionately greater users of prescription drugs.

It is important that the benefit package and periodicity schedules are based on consistent and scientific guidelines in order to avoid confusing and conflicting message to the public. Decisions regarding the benefit package and periodicity schedule should not be based primarily on budgetary concerns but on what is best for the public.

Because women suffer disproportionately from mental health conditions including depression and low self-esteem, it is especially important for women that full mental health benefits be phased in as quickly as possible.

Long-Term Care. The Health Security Act would have a new long-term care benefit that covers care at home or in the community, without regard to income, allowing seniors and severely disabled Americans to stay in the community. This provision would benefit women in particular, since more older women have limitations in daily activities.

Under the Health Security Act, states would be able to disregard up to \$12,000 in assets of a single person when determining eligibility for nursing home coverage. Again, since women live longer than men, are more likely to be frail and to live alone, and comprise 72 percent of nursing home residents, this benefit would be of particular significance to women.

While an important step, the Health Security Act's long term care benefit needs to be strengthened. It would be more beneficial to elderly women and men if the provision of home and community based care was a covered Medicare service, rather than a block grant to states. Arbitrary spending caps are likely to confuse beneficiaries and lead to unmet expectations. The new long-term care provision fails to address major gaps in providing health security for elderly Americans. Millions of Americans with milder impairments would not be covered for home and community-based care. Medicaid would continue to be the country's major source of nursing home coverage, requiring the elderly to spend down in order to qualify for coverage or to spend high out-of-pocket costs for nursing home care.

Insurance Market Reform. Many women in this country who have suffered serious health conditions, ranging from breast cancer to diabetes, often face the added worry of not being able to obtain health insurance, either because of "pre-existing condition" clauses or

underwriting practices. These women would benefit from the insurance market reforms under the Health Security Act, which include community rating, portability of coverage and which prohibit health plans from denying coverage based on health, employment or financial status.

Managed Care. The Health Security Act provides strong incentives for Americans to participate in managed care plans. This is particularly true for low income women, who are most affected by the premium and cost-sharing provisions. High cost-sharing in the fee-for-service option makes it a non-feasible choice for millions of poor women. Given this, it is troublesome that women in HMOs are less satisfied with their physicians than non-members.

As states begin to mandate that Medicaid enrollees join managed care plans, the ability of these plans to address this group's needs should be carefully assessed. HMOs currently serve a younger, healthier population and would have to adjust to the needs of a more vulnerable population.

Family choice is another important issue for women. Under the Health Security Act, family members would choose one health plan. Half of women receive care from two physicians--typically a family physician and a gynecologist/obstetrician. If the fee-for-service option is not a realistic option, women may be forced to change at least one of these physicians. Additionally, if a woman's regular physician is in one health plan and her husband's physician practices in another, some women would have to change their source of care. Letting individual family members enroll in different plans would reduce, but not eliminate some of these problems.

It will be important to assure that discrimination against high risk populations does

not occur under the Health Security Act. While the risk-adjustment methodology in theory would ensure that health plans would receive more money for serving high risk populations, in practice, the Act has not clearly specified this methodology and no adequate method currently exists to overcome this problem.

Financing. Under the Health Security Act, the major source of financing is cuts in Medicare and Medicaid. As a result, women would bear the brunt of these cuts. Current Medicaid beneficiaries, including pregnant women, would be strongly affected by the cuts. In the place of Medicaid coverage, they would be required to pay substantial premiums, cost-sharing, and lose supplemental services. Health alliances may not be sensitive to the needs of poorer women, including transportation and language barriers. The inadequacy of subsidies for premiums and cost-sharing for poor and near-poor families is a crucial issue.

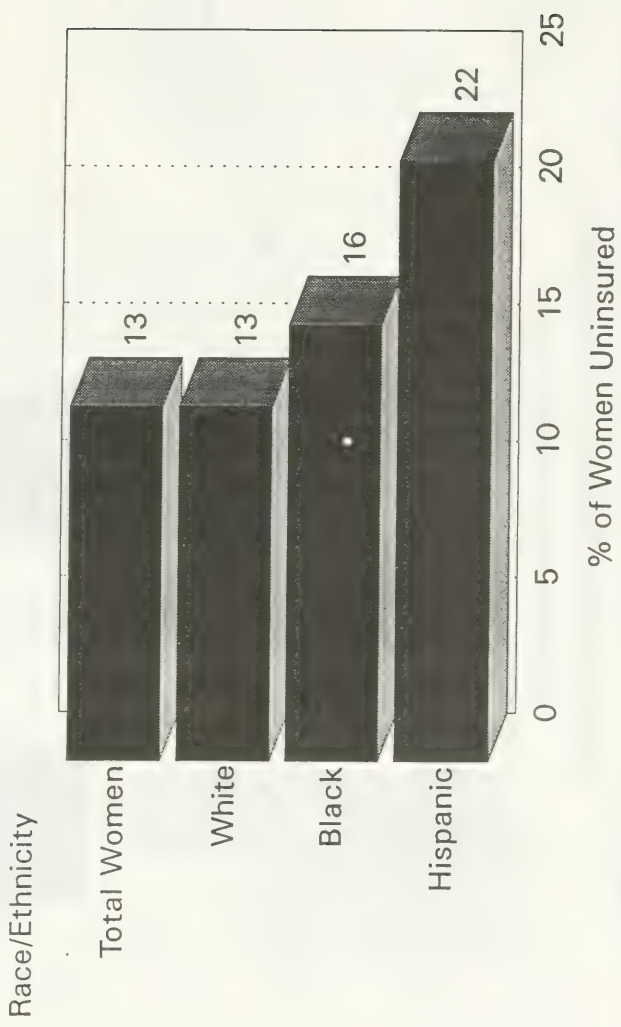
The timing of the cuts in Medicare and Medicaid is also important, especially for the poor. Hospitals now receive payments through Medicare and Medicaid if they serve a disproportionate share of poor patients. These payments would be sharply reduced. Yet, institutions serving the poor are likely to continue to experience bad debts--from unrealistic cost-sharing, non-covered services, or limits on benefits (such as mental health and substance abuse). It is very important that these payments continue at a level sufficient to assure the adequacy of services in low-income communities.

The President's promise to offer universal health insurance for all Americans is an historic step that would greatly increase women's access to care and improve the health and

well-being of all American women, especially the most vulnerable. However, the plan needs to be strengthened in order to assure that all Americans have access to the benefits they need. Limitations on benefits would have the most adverse effects on poor women, who would not have the ability to pay out-of-pocket for care that is not covered. The plan must provide better assistance to low income women and men, especially those who would be most affected by cuts in Medicaid and Medicare. For coverage to be truly universal, coverage must be affordable and benefits must be comprehensive. Otherwise health care reform delivers an empty shell--without making needed health care accessible to all Americans.

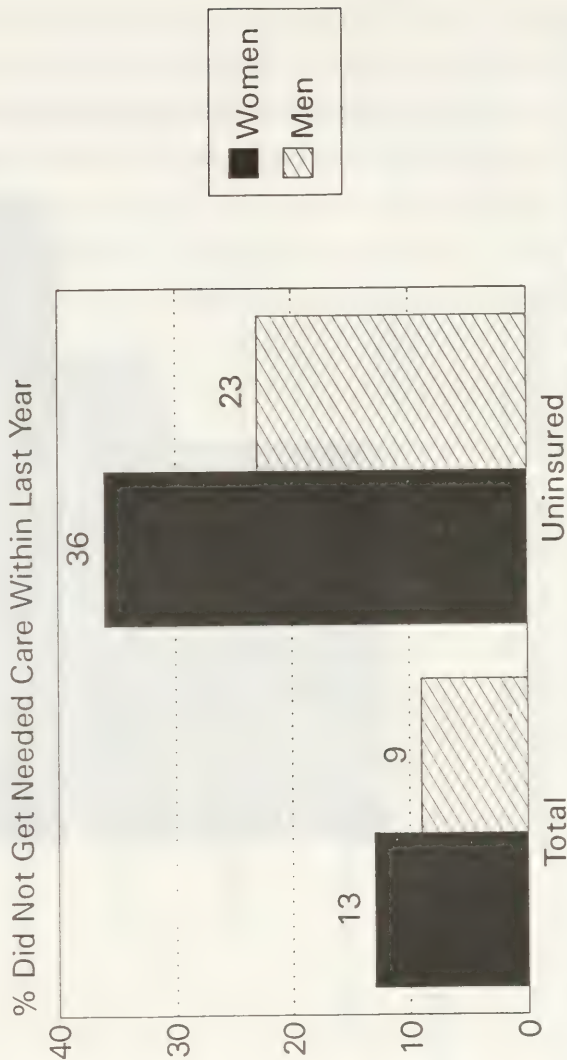
Uninsured Women By Race/Ethnicity

Hispanic Women Most Vulnerable

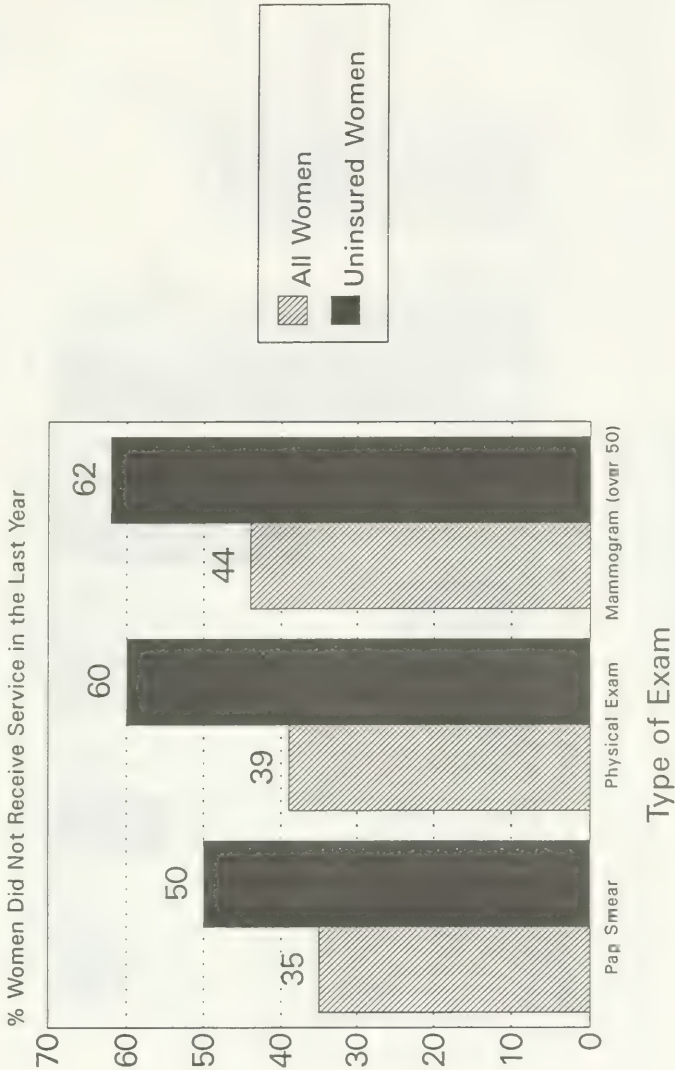


Access to Needed Medical Care

Women More Vulnerable Than Men
Uninsured At High Risk



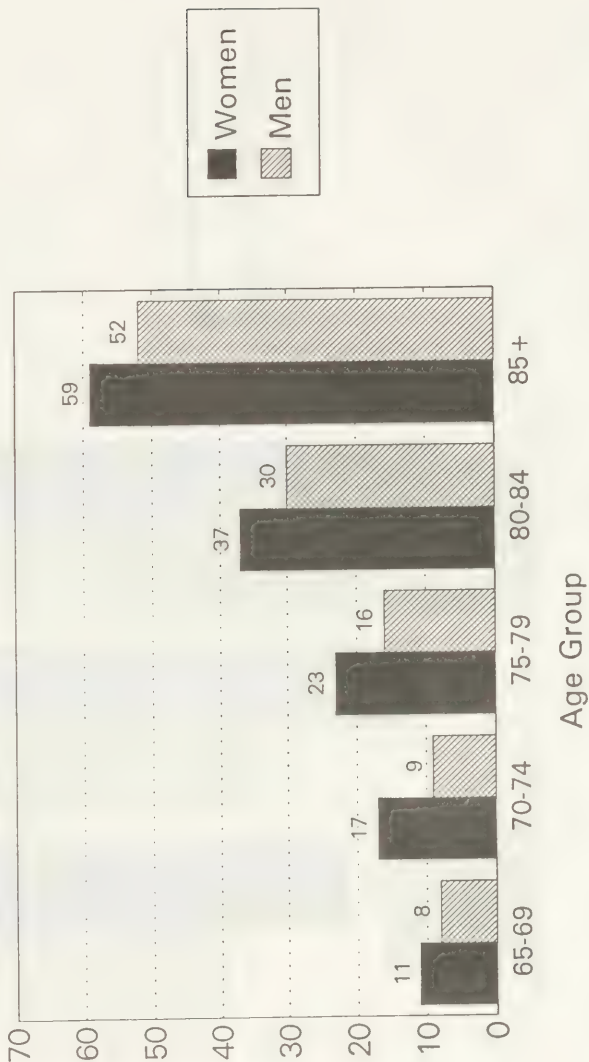
Uninsured Women Less Likely to Get Preventive Care



The Commonwealth Fund Woman's Health Survey
Louis Harris and Associates, Inc., 1993

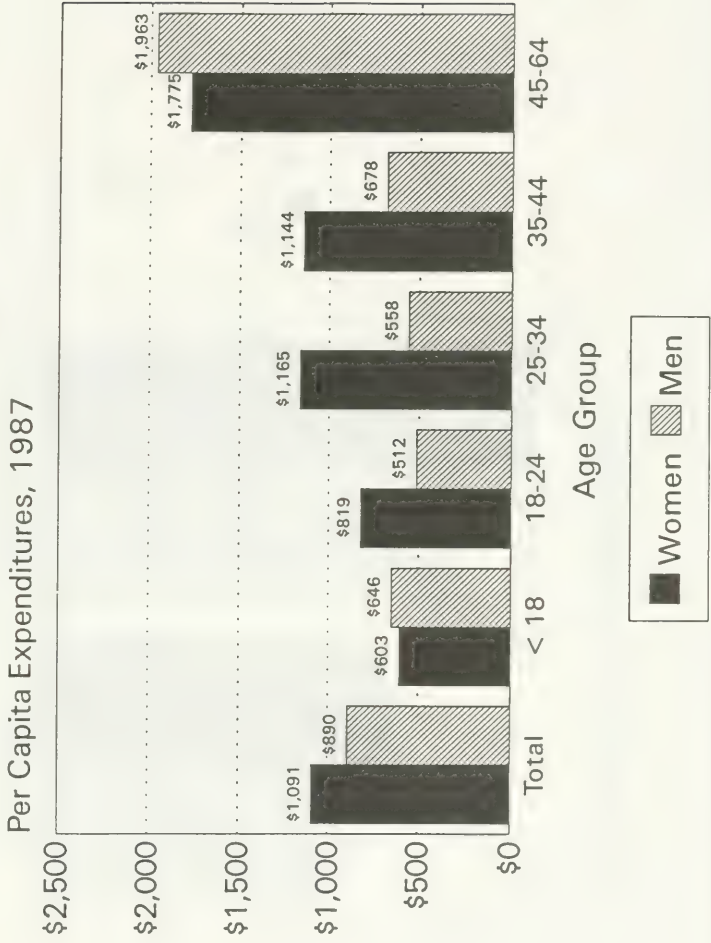
Older Women Have More Limitations in Daily Activities Than Older Men

Percent with at least one ADL or IADL *

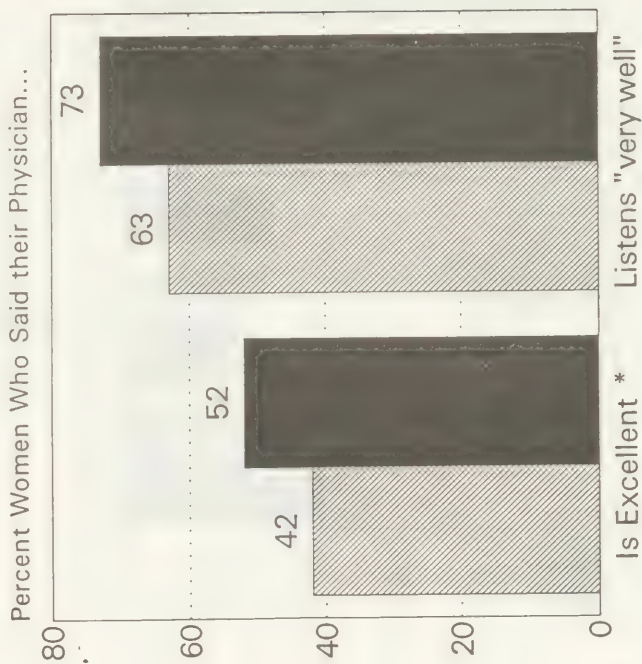


* ADL = Activity of Daily Living, IADL = Independent Activity of Daily Living

Expenditures Per Capita, 1987



Women in HMOs Are Less Satisfied with their Physicians



17

The Commonwealth Fund Women's Health Survey
 Louis Harris and Associates, Inc., 1993

* in providing good health care overall

The Health Security Act: Critical Issues for Women

- **Universal Coverage**
- **Comprehensive Benefits**
- **Long-Term Care**
- **Insurance Market Reform**
- **Managed Care**
- **Financing**

Mr. WAXMAN. Miss Dooley.

STATEMENT OF BETTY DOOLEY

Ms. DOOLEY. Congressman Waxman, I want to thank you and the other members of your committee for holding this hearing today.

Today we are releasing a study entitled Women's Health Insurance Costs and Experiences. This study was made possible by a grant from the Kaiser Family Foundation. Our report relied on data from the National Medical Expenditure Survey. The analysis was conducted by Lewin-VHI, a nationally known consulting firm.

Our report is the first of its kind to examine the cost to women for reproductive and preventive services. It shows that women are especially vulnerable to high health care costs and women usually have lower incomes than men. It demonstrates that low-income women, unemployed women and uninsured women are at a great disadvantage in our present health care system.

Here are some of the highlights of our report.

Women of childbearing age between 15 and 44 are twice as likely as men in their age group to use preventive services. Preventive services test like Pap smears and mammograms, though routine, can save lives, yet many women in our society lack coverage for reproductive care. These are the uninsured, those who have insurance that exclude these services or those with high deductibles and coinsurance that, in effect, provide barriers for this care.

The result is higher out-of-pocket costs. Women in this age group pay 68 percent more out-of-pocket than men do, and these expenses come after taxes have been paid. And we are also very troubled to find that $\frac{1}{4}$ of poor women have out-of-pocket expenses that exceed 10 percent of their income.

This report underscores the importance of reproductive and preventive services being covered in health care reform. One example: In 1993, a woman with a pregnancy-related stay in the hospital paid out-of-pocket on average \$1,100.

But high out-of-pocket costs are just part of the story. Keep in mind that high health care costs discourage women from getting needed care. Sixty percent of black and Hispanic women do not get preventive services, and a majority of uninsured women do not get preventive care. And the lower income, the less likely a woman is to receive preventive care. Fifty-five percent of women below the poverty line do not get preventive care.

In summary, women have much to gain from health care reform. The President's Health Security Act would dramatically improve women's access to preventive and reproductive services, but the catch-22 with this plan and others may be in the benefit package and the formulas in place for out-of-pocket costs. Women have the children that perpetuate the race. If it were not for that fact, women during these years would have approximately the same costs for their health care that men have.

Pat Schroeder earlier today talked about a fair shake for women. I think we would say from our study that women need more money spent on their health care than men do. We urge you to remember this when you tackle health reform.

Thank you, Congressman Waxman.

Mr. WAXMAN. Thank you very much, Miss Dooley.

[The prepared statement of Ms. Dooley follows:]

WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES

Testimony Presented before
The Subcommittee on Health and the Environment
by the
Women's Research and Education Institute
January 26, 1994

I am Betty Dooley, Executive Director of the Women's Research and Education Institute. I want to thank you, Congressman Waxman, and the members of the Subcommittee on Health and the Environment for this opportunity to testify before you today. I commend you and the other members of the Subcommittee for holding this hearing on the important topic of women's health and health care reform.

My remarks are taken from a study which we are releasing today, entitled Women's Health Insurance Costs and Experiences. This report was supported by the Kaiser Family Foundation as part of the Kaiser Health Reform Project.

Our report is the first of its kind to examine how much it costs women to look after their reproductive and preventive health care needs. It shows, in a nutshell, that women are particularly vulnerable to high health care costs. This is because women are more likely to use services—especially reproductive and preventive services—and usually have lower incomes than men. Furthermore, the report demonstrates that low-income women, unemployed women, and uninsured women are especially disadvantaged in our present health care system.

This report, prepared by the Women's Research and Education Institute, relied on data from the 1987 National Medical Expenditure Survey. This survey represents the most recent nationally representative data describing the health care use and expenditures of Americans. The analysis of the National Medical Expenditure Survey was conducted by analysts at LEWIN-VHI, a nationally-known consulting firm that regularly conducts analyses for the U.S. Department of Health and Human Services.

Let me take a few minutes to describe some of the principal findings of our report: First of all, this study shows that women of childbearing age are more likely to use health care services than men, largely because of their greater need for preventive and reproductive services. In fact, women age 15 to 44 are twice as likely as men in their age group to use preventive services.

Unfortunately, many women lack adequate coverage for reproductive and preventive services. In many cases, women lack coverage because they are uninsured altogether. In other cases, they lack adequate coverage because their insurance plans exclude reproductive and preventive services or require deductibles and copayments.

The result is that women of childbearing age have higher out-of-pocket costs for health care than men have. In fact, they pay 68 percent more out-of-pocket than men do. When you

consider that women's incomes are lower than men's, their health spending looks particularly troublesome: Over twice as many women of childbearing age have out-of-pocket expenditures that exceed 10 percent of their income, compared to men in this age group. Stated differently, women account for 7.4 million of the 10.8 million Americans age 15 to 44 who have out-of-pocket health expenditures in excess of 10 percent of their income. (I refer you to figure one.)

Uninsured and low-income women are especially vulnerable to high out-of-pocket costs: Almost 20 percent of uninsured women have out-of-pocket expenditures that exceed 10 percent of their income. Especially troubling is the fact that one-fourth of poor women of childbearing age have out-of-pocket costs that exceed 10 percent of their income. (I refer you to figure two.)

Our report also underscores how important it is that reproductive services be covered in health care reform. Reproductive services account for a large portion of women's health spending. In fact, expenditures for reproductive services for women of reproductive age total \$40.7 billion. This represents one-third of all health expenditures for women in this age group. For an individual woman, out-of-pocket costs for reproductive services can be very steep. One example illustrates this point: Women with a pregnancy-related hospital stay pay nearly \$1,100 out-of-pocket for these hospital stays.

This look at women's spending for health care services tells only part of the story. The other part is that high health care costs discourage women from receiving needed care in the first place. The data show that disadvantaged women are less likely to receive needed preventive services. Here are the statistics, as described in figure three.

- * The majority of black and Hispanic women don't get preventive services. In fact, almost 60 percent of black and Hispanic women fail to receive preventive services.

- * In addition, the majority of uninsured women don't get preventive services. In fact, 60 percent of women without health insurance fail to get preventive services.

- * Especially troubling is the finding that the lower a woman's income, the less likely she is to receive preventive services: A full 55 percent of women below the poverty line do not get preventive care.

In summary, I would say that women have a great deal to gain from health care reform. President Clinton's Health Security Act would make some major changes in improving women's access to preventive and reproductive services. Universal insurance coverage would mean that no woman would be left wholly responsible for her health care costs. Health insurance coverage, by itself however, is not enough. Women need a comprehensive benefits package that includes reproductive and preventive services with minimal copayments and adequate subsidies for those who have low incomes.

The President's Health Security Act takes important steps in this regard as well. Family planning, prenatal care, abortion, and contraceptives are all included in the basic benefits package. The financing of the President's plan has more ambiguous implications for women. Low-income persons would receive subsidies for the purchase of health insurance, but the level of those subsidies may be insufficient for low-income women. If women sign on to managed care plans, no copayments would be required for preventive services, but a copayment would be required for reproductive services.

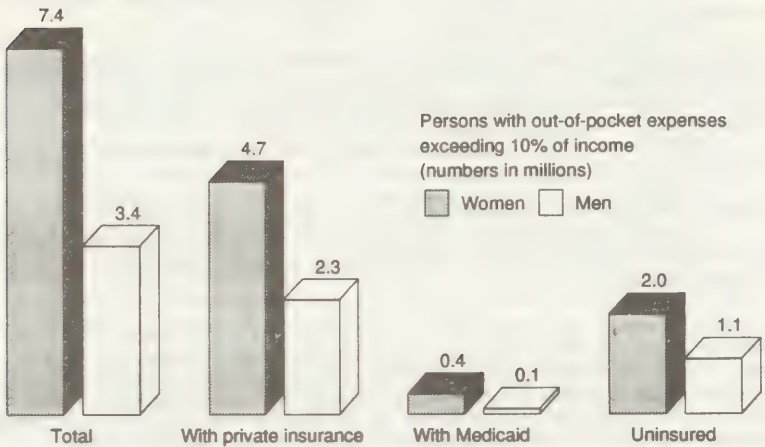
Health care reform must ensure that costs no longer serve as a deterrent to seeking preventive and reproductive services. Providing subsidies for low-income women to enable them to purchase insurance would solve part of the problem. In addition, copayments should be eliminated for the preventive and reproductive services that women require. Only then will health care reform eliminate the financial barriers that discourage women from receiving the care they need.

Figure 1 · Persons age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by type of insurance coverage.*

MORE THAN TWICE AS MANY WOMEN AS MEN AGE 15 TO 44 HAVE OUT-OF-POCKET HEALTH EXPENDITURES THAT EXCEED 10 PERCENT OF THEIR INCOME.

● **Women account for 7.4 million (69 percent) of the 10.8 million Americans age 15 to 44 who have out-of-pocket health expenditures of more than 10 percent of their income.**

● **Almost 5 million privately insured women age 15 to 44 have out-of-pocket expenditures of more than 10 percent of their income.**



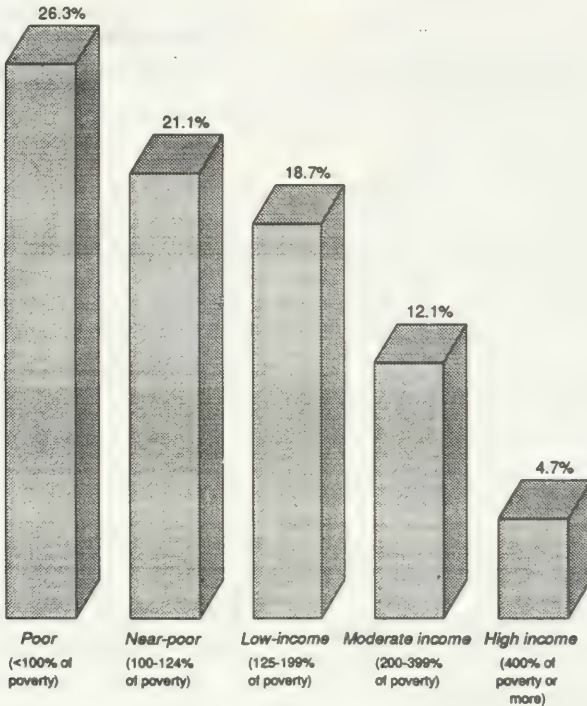
* Out-of-pocket expenditures as a percent of income are calculated by dividing an individual's out-of-pocket expenditures for health care services during the year by an individual's share of family income. An individual's share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels. The project is funded by the Kaiser Family Foundation, as part of the Kaiser Health Reform Project.

Figure 2 · Proportion of women age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by income level.*

OUT-OF-POCKET HEALTH EXPENDITURES ARE MOST BURDENSOME FOR THE POOREST WOMEN.

- **More than one-fourth of poor women of childbearing age have out-of-pocket health expenditures that exceed 10 percent of their income.**



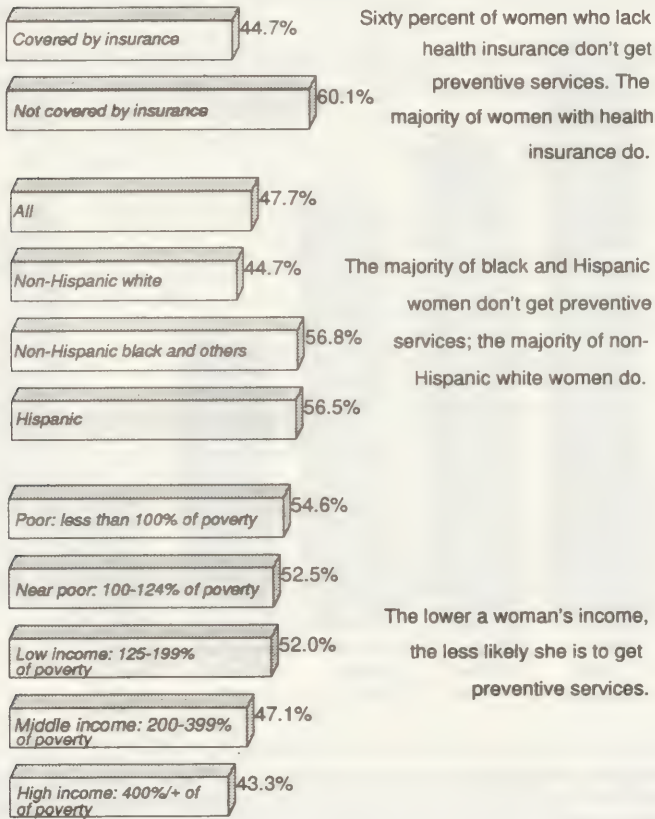
* Out-of-pocket expenditures as a percent of income are calculated by dividing an individual's out-of-pocket expenditures for health care services during the year by an individual's share of family income. An individual's share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels. The project is funded by the Kaiser Family Foundation, as part of the Kaiser Health Reform Project.

Figure 3 · Percent of women age 15 to 44 who do not use preventive services, by race/ethnicity, insurance coverage, and income level.

LACK OF HEALTH INSURANCE IS LIKELY TO MEAN LACK OF PREVENTIVE CARE FOR WOMEN AGE 15 TO 44. BEING OF COLOR AND/OR HAVING A LOW INCOME ALSO REDUCE WOMEN'S USE OF PREVENTIVE CARE.

**PERCENT NOT USING
PREVENTIVE SERVICES**



Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels. The project is funded by the Kaiser Family Foundation, as part of the Kaiser Health Reform Project.

Mr. WAXMAN. Miss Kuriansky.

STATEMENT OF JOAN A. KURIANSKY

Ms. KURIANSKY. First, speaking on behalf of the campaign we want to thank you for your leadership—historic leadership—in promoting women's health concerns, particularly in the area of research. And I know as we talked today we are talking to the converted, and we would just say thank you for your leadership.

The campaign today—

Mr. WAXMAN. I was not converted. I was there from the beginning.

Ms. KURIANSKY. Part of the converters.

The campaign today is 90 organizations strong. We represent national, State and grass roots organizations who are concerned about advancing women's health concerns in health care reform. Our coalition represents more than 8 million individuals nationwide.

We have already heard excellent testimony today from many Members of Congress and others on the current status of women's health. I just want to say that it is that failure of both the system, whether it relates to medical research, health care delivery or payment, that has prompted us to create a set of standards and principles which we use in evaluating whether health care reform principles meet women's needs.

The principles are several pages long. I want to highlight five of them and compare them to the President's health care plan.

Our major principles by which we evaluate plans are universal and equal access, affordable costs, comprehensive benefits, choice of providers and settings and accountability to ensure that the health care system meets women's needs.

Of the bills currently before Congress, only two substantially address the principles of the campaign: the Health Security Act and the Wellstone-McDermott act. Other proposed legislation all fall far short of meeting the principles we have articulated.

Importantly, the Health Security Act, as we have heard, already provides health coverage for all citizens and legal residents. This is the cornerstone of major health reform, and it is particularly true because of the status of women—both employment and marital status—that up until now has so denied her coverage. And I think Karen spoke to that so I will not continue, other than to say that we are still concerned about some of the potential impediments, even with the statement of universal coverage.

First, we are concerned that thousands of undocumented women who work and contribute to society will not be entitled to much-needed services such as prenatal care.

We are also concerned, as we have heard from members of the panel, about women's ability to pay the required premiums and copayments. We are afraid that those standards right now may make universals access for women difficult to achieve. This is particularly true for certain categories of employed and unemployed women who earn far less than their male counterparts. With the median income of American women approximately \$10,700, the 3.9 percent maximum income cap on the family portion of the premium may be an obstacle to care.

We are also concerned that there are no limits on the total premium of a nonworker. Subsidies at or below 150 percent of poverty may be insufficient, and caps on Federal premium subsidies are particularly troubling.

We are also concerned that supportive services for current Medicaid-eligible women, such as transportation, child care, translation services, will not be universally available.

Further, we oppose any attempt to reduce the number of employees required to set up an alliance. Any reduction of the pool of health plan participants, we believe, will encourage cherry picking among alliances and would severely disadvantage the most vulnerable population, many of whom are women.

As we look at the benefits package, we are clearly encouraged. We applaud the President for including a mandated comprehensive package and particularly one that addresses preventive as well as primary care. Although we are going to hear later on panels both on reproductive health and breast cancer, we want to reiterate here our commitment to ensure that reproductive health in its broadest definition is included in this health care package, and by that we mean reproductive health care services including family planning, prenatal, maternity, well baby, abortion services, mammograms and STD-trained screenings. These are all integral to women's health.

Should Congress decide that it wants to treat abortion different from any other service, we must really ask what is the meaning of a comprehensive benefits package? Clearly, if there is a failure to include that service in this plan, it leaves open a whole range of services and a whole range of categories that we would find very troubling.

Importantly, the Health Security Act also provides a prescription drug benefit and a long-term care programming which promotes home- and community-based care.

We have several comments on long-term care. Our most grave concern is that it stops at home- and community-based care and does not acknowledge or respond to all the women who currently are spending down to poverty as they are in nursing homes.

We are also pleased that there are a choice of providers and settings included in the health care plan, although we would like to see some statements on the Federal level as well as on the State level.

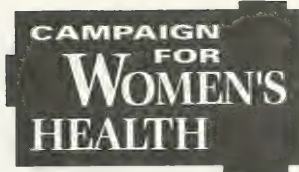
And, last, I want to comment on the failure of any of the plans to specifically mandate the inclusion of women or women's health experts for representation on any of the boards, commissions or other advisory regulatory bodies. We think it is critical that women be represented to assure that a new health care system is accountable to and meets the needs of all women.

And with that I will conclude and would like to have my written comments included in the record.

Mr. WAXMAN. Yes, certainly, your full statements will be in the record.

Ms. KURIANSKY. Thank you.

[The prepared statement of Ms. Kuriansky follows:]



TESTIMONY BEFORE
THE U.S. HOUSE OF REPRESENTATIVES
SUB-COMMITTEE ON HEALTH AND THE ENVIRONMENT
JANUARY 26, 1994

Chairman Waxman, thank you for the opportunity to testify before this committee on health care reform and its potential impact on the women of America. I am Joan Kuriansky, convenor of the Campaign for Women's Health and the executive director of the Older Women's League.

The Campaign for Women's Health is a broad-based coalition of ninety national, state and grassroots organizations convened to advance women's interests in health care reform. Our coalition represents more than eight million individuals nationwide. The Campaign for Women's Health was convened in 1991 with the goal of ensuring that women have a strong voice in the debate on health care reform, and one commensurate with our numbers.

As 52% of the population, women are the major consumers of health care. Women are also the major health caregivers, whether employed as nurses, doctors, hospice workers and health educators, or as the unpaid caretakers of family members. Women's health is everyone's health.

Yet, more than 12 million American women have no health insurance of any kind. Many millions more have inadequate insurance with health services, such as preventive care, unavailable or so limited as to fail to assure women's most basic health needs. Medicaid and Medicare are critical programs but, they fall short of meeting women's health needs. Certain diseases and conditions are unique to, more prevalent, or more serious in women. For instance, hysterectomy is one of the most commonly performed major surgeries with approximately 600,000 performed annually. One out of nine women will be diagnosed with breast cancer, with more than 180,000 new cases in 1994 and more than 46,000 deaths. Women experience osteoporosis at a far greater rate than men, with one out of three women, as compared to one out of six men over age sixty-five, developing this disease. Depression

A Project of O.W.L.

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is more prevalent in women, with a rate twice that of men. And violence against women, a long-ignored threat to their health, is the single major cause of emergency room visits by women.

Access to health coverage is more limited for women than for men because coverage is determined by employment and marital status, two factors which unfairly disadvantage women. More women than men work part-time, in small businesses, in sales or clerical jobs, and as household and day workers where health benefits are often unavailable. Many women are covered as dependents through their husbands insurance and yet, coverage through a spouse is risky, at best, as insurance companies continue to cut back on dependent coverage or eliminate it altogether. And, a national divorce rate of fifty percent leaves many women without coverage when marriages fail.

For too long, women have been treated as second class citizens in the health care system, unable to access the health care services that will protect and promote their health. Health care reform is a critical moment to right the wrongs American women have endured for far too long.

The Campaign for Women's Health Principles

The Campaign has developed a set of principles by which we measure whether a health care reform proposal will meet the health needs of women. These principles include:

•**Universal Access.** Every individual must be covered for health care services.

•**Equal Access.** The ability to pay, employment, health, age, marital and residency status must not be barriers to care. All women should have access to a single, high-quality standard of care.

•**Affordable Costs.** The cost of health care must be affordable, and cost-sharing in the form of copayments and deductibles must not constitute barriers to care.

•**Comprehensive Benefits.** Comprehensive health services must include a full range of preventive, primary, reproductive health, and long term care services. A broad standard requiring all services which are necessary or appropriate for the maintenance of health must be established.

•**Choice of Providers and Settings.** Health services must be available from a range of providers, including physicians, advance practice nurses, health educators, and other allied health providers. Health services must be available in a range of settings, including hospital and outpatient settings,

practitioner's offices, the home, and long term care settings. Services must be community based and transportation, child care, and financial assistance should be available.

•Accountability. Women must be part of the decisions made in the design and implementation of reform. Women representing a broad spectrum of the women's health community should be appointed to boards, commissions, and other advisory and regulatory bodies of a new health system.

Current Health Care Reform Proposals

Of the health care reform bills currently before Congress, only two substantially address the principles of the Campaign for Women's Health: the Health Security Act, HR 3600/S 1757 and the Wellstone/McDermott American Health Security Act, S 491/HR 1200. Other proposed legislation such as the Chafee, Michel, and Cooper/Breaux plans all fall far short of meeting the principles we have articulated. Our analysis is as follows:

Universal Access. Both the Health Security Act and Wellstone/McDermott plans state that they will provide health coverage for all United States citizens and legal residents. We are concerned that under the Health Security Act women's ability to pay premiums and copays as well as certain categories of employed and unemployed women (such as part time workers, day workers, and displaced homemakers) may make universal access for women difficult to achieve. Undocumented residents are not fully covered. We are concerned that thousands of undocumented women who work and contribute to society will not be entitled to much-needed health services such as prenatal care. The costs of caring for undocumented women and their children in emergency rooms is an inefficient and expensive use of health resources.

The Chafee health plan requires all individuals to obtain health coverage if not provided by employers. Requiring individuals to obtain coverage is not the same as ensuring coverage. Many women, especially those who are less likely to be employed full time, working at low wages, or unemployed will be unable to afford coverage. The Michel and Cooper/Breaux plans have no requirement for coverage. Under these two plans, individuals may voluntarily purchase health insurance coverage. Such a voluntary system would fail to assure universal access to women, millions of whom will be forced to remain outside the health care system.

Equal Access. Both the Health Security Act and the Wellstone/McDermott plans state that no individual can be denied access to care on the basis of ability to pay or employment. Pre-existing health conditions cannot preclude coverage or increase premiums. The plans state that age and marital status do not impede access. Under the Health Security Act the ability to pay

for premiums, copays and deductibles could be a barrier to access for low-income women. The median income of American women in 1992 was \$10,774. Subsidies for women at or below 150% of poverty may be insufficient and caps on federal premium subsidies are a troubling prospect. In addition, the 3.9% maximum income cap may be too high for many low-income women. We are also concerned that supportive services for currently Medicaid-eligible women, such as transportation, child care, translation services, would become unavailable. Additionally, if the alliance structure were changed, many women whose employment status is marginal (such as part-time workers, day workers, etc.) would find themselves accessing a two-tiered system rather than one with a single standard of care for all citizens.

The Chafee plan provides vouchers to help subsidize low-income individuals. However, the amount of the vouchers would depend on the level of savings accrued under the plan, a system which makes women's access to health services dependent on the already risky and overblown health economy. Both the Michel and Cooper/Breaux plans provide subsidies for low-income individuals but, inadequate subsidies would constitute major barriers to access for many women. Both the Chafee and Michel plans impose some restrictions based on pre-existing conditions, a situation which would effectively deny access to care to millions of women, many of them the women most in need of care for the conditions they already have. Two million American women will be diagnosed with breast cancer in this decade. Approximately two-thirds of these women will survive breast cancer, thanks to medical advances, but they could face the irony and prospect of no health coverage to continue to protect their lives and health. The Cooper/Breaux plan prohibits denial or limitation of coverage due to health status.

None of the plans specify how access to a single standard of high-quality care will be assured. This is an important aspect of health care reform for women, especially low-income, rural, inner city, and minority women who traditionally receive care of a far lesser quality than their majority, middle-class counterparts. For example, a conscience clause could prohibit some groups of women from access to abortion services, while more affluent women travel and pay for these services elsewhere.

Affordable Costs. Under the Health Security Act individuals with income at or below 150% of poverty will receive subsidies to cover the cost of care. Out-of-pocket costs will depend on the type of plan chosen. No co-pays for preventive care. Maximum out-of-pocket costs are \$1500 for single individuals and \$3000 for families. There are no subsidies for the copays in the low cost-sharing plan for those above 150% of poverty. There are caps on federal premium subsidies for low-income citizens and a 3.9% maximum income cap for low-income individuals. We are concerned that several of these components may be barriers to care for low-income women and their families. Subsidies may be too low and women's limited income for copays would preclude their access to services. For example, a low-income mother might find it

prohibitive to pay copays for multiple visits for her several children.

The Wellstone/McDermott plan does not require co-payments. However, HR 1200 leaves open the possibility of some cost-sharing for long term care services, which could be problematic for older women and women as caregivers to the elderly and disabled. There are no premiums to pay as the plan is financed through taxes.

The Chafee plan includes co-payments for all services except preventive care. A National Benefits Commission will specify the amounts of copays and the limits on out-of-pocket costs. We are concerned that the vagaries of unspecified copays and limits could take affordable costs out of the reach of low-income women and women on fixed incomes.

The Michel plan has no limits on copays and no federal limit on out-of-pocket costs. Medical savings accounts with high cost sharing are encouraged. No limits on copays and out-of-pocket costs would deny access to care to many women and make low-income women especially vulnerable to foregoing the health care they need.

The Cooper/Breaux plan includes copays for all services except preventive health services. There are no federal limits on out-of-pocket costs. A national health board will establish limits on yearly cost sharing for an individual per year. We are concerned that the lack of federal limits will place the burden of out-of-pocket costs on those who can least afford it and who are often in the most need of care.

Comprehensive Benefits. The Health Security Act includes a guaranteed national benefits package, including a schedule of clinical preventive services. The plan includes "family planning services" and "pregnancy-related services" but, the scope of these services is not defined. A limited long term care program is included, covering home and community-based services. The plan applies a broad standard to define covered services, calling for all services that are medically necessary or appropriate to health. We applaud the Health Security Act for including a comprehensive benefits package which goes a long way towards meeting women's needs.

The Wellstone/McDermott plan covers a similarly broad range of services, including primary and preventive care. Family planning services, prenatal and well baby care are covered but, the scope of these services is not defined. The plan calls for long term care services to include nursing home care as well as home and community-based care. The plan applies the broad medically necessary or appropriate standard for the inclusion of benefits. The Campaign for Women's Health applauds the Wellstone/McDermott bill for offering a generally comprehensive set of benefits for women.

The Chafee plan offers a standard benefits package and an optional catastrophic package, both unspecified as to details. The National Benefits Commission will create, with Congress' approval, the standard benefits package that "can be covered with a reasonable, affordable premium." Reproductive health services are

not mentioned as one of the broad categories of services to be covered. No new long term care program is included. The plan specifies that all services in the benefits package must be medically necessary or appropriate as defined in the legislation. We are concerned that a benefits package tied to premiums will mean more limited health services for women, with reproductive health care most at risk. Long term care is also an essential and much-needed set of services for women and must be included in health care reform.

The Michel and Cooper/Breaux plans have no defined benefits packages and neither plan mentions reproductive health care. No new long term care program is included in either plan and Cooper/Breaux eliminates all federal spending for Medicaid long term care. The Michel plan will cover only essential and medically necessary services. The Cooper/Breaux plan will include a standard much like that in the Chafee plan. Both these plans fail to offer a benefits package to meet women's health needs.

Choice of Providers and Settings. The Health Security Act and Wellstone/McDermott plan do not limit or exclude any types of health care providers and defer to the states to determine the eligibility of providers. We are concerned that the full range of providers of women's health will not be met if not more clearly delineated in the plans. Women need care not only from physicians but, from nurse practitioners, clinical nurse specialists, certified nurse midwives, community midwives, licensed clinical social workers, optometrists, podiatrists, psychologists, physical therapists, health educators, and a number of allied health practitioners.

The Chafee plan defers to the states to specify authorized categories of providers. The Michel plan makes no definition of provider. The Cooper/Breaux plan states that the National Health Board may not restrict or require coverage for treatment from a particular class of provider and defers authority to the states. These three plans do not ensure that women's needs for a wide choice of health care providers will be met.

The Health Security Act and Wellstone/McDermott plan provide reimbursement of services in a variety of settings. Family planning clinics and school-based clinics are specifically mentioned in both plans, both important sources of care for women.

The Chafee plan provides grants for health centers to improve delivery of care to frontier, rural, and urban underserved areas. Family planning clinics are not mandated as reimbursed providers, an essential setting for women's health care.

The Michel and Cooper/Breaux plans make no mention of a variety of settings, apart from integrating health centers in underserved areas into the plans. These two plans do not adequately address women's needs for a range of health care settings.

The Health Security Act includes "essential community providers" to provide community-based care. Public health and health care access initiatives are intended to increase access to

care.

The Wellstone/McDermott plan includes community-based services in the benefits package. Provides grants to establish primary care centers in underserved urban and rural areas.

The Chafee plan includes public health initiatives for underserved areas to increase the number of primary caregivers and their training.

The Michel plan provides grants to community centers for primary care in underserved areas. Funds available to expand emergency services in rural areas.

The Cooper/Breaux plan requires neighboring health plans to extend coverage to underserved areas, providing federal funds to entities establishing a network plan in an underserved area.

Women need care not only in hospitals and physicians offices but, in community health centers, clinics, skilled nursing centers, long term care facilities, hospices, other specialized centers such as rehabilitation facilities, and in a variety of outpatient settings such as the offices of nutritionists, acupuncturists, and psychotherapists, to mention a few. We are concerned that none of the plans go far enough in specifying the range of settings women need.

Accountability. None of the plans specifically mention women's interests, women, or women's health experts to be assured representation on any of the boards, commissions, and other advisory and regulatory bodies. The Campaign for Women's Health principles state that it is essential that women be represented in such fashion to assure that a new health care system is accountable to and meets the health needs of all women.

Conclusions

While the above summary of our analysis is by no means complete, it is clear that only the Health Security Act and the Wellstone/McDermott plan begin to meet the health requirements of women. Even so, many aspects of both these plans need clarification, change, and expansion in order to assure women the health care they need and deserve. The Campaign for Women's Health will continue to monitor and suggest alterations and inclusions to plans as they progress through Congress and as they are eventually implemented.

The Campaign for Women's Health would like to submit for the record a copy of our *Model Benefits Package for Women in Health Care Reform*. This package was specifically designed to meet the comprehensive health needs of women. We include a full range of primary and preventive care, primary and preventive reproductive health care, long term care, and a wide range of health care providers and settings as fundamental to protecting and promoting the health of women in a reformed health system.

Health care reform offers our country the unique opportunity to redress the many inequities women have long faced and continue to face in securing the health care they need. In crafting health care reform we must look to the most vulnerable, the most poorly served, and the most in need, with the majority being women, to guide us in creating a new health system which meets the needs of all, not just some, of our citizens.

Mr. WAXMAN. I want to thank the three of you very much for your testimony.

Let me ask you this. Some of my colleagues on this subcommittee are sponsors or cosponsors of bills that would not give us a guarantee of universal coverage. They would make some changes in the insurance system. They would try some theories of competition to see if that would produce a more efficient marketplace. But if Congress adopts a plan that does not provide universal coverage, where will women end up? Will more women or more men end up without adequate health care security?

Ms. DOOLEY. More women.

Ms. DAVIS. I think universal coverage is absolutely essential to assure that women will not lose coverage when they change jobs, when they change their employment status.

And I think you are right. The President's plan does provide for universal coverage. Some of the other major bills do not, such as Congressman Cooper's bill.

But even those that would try to achieve universal coverage, such as an individual mandate, may fail to do so if there is not adequate revenues to support subsidies for the premiums of low-income people. We know that about two-thirds of the uninsured have incomes below twice the poverty level or that is about \$22,000 for a family of three. That family cannot afford a \$5,000 premium without some financial assistance.

So I think to achieve universal coverage we are really going to have to have either an employer mandate or a commitment of new revenues—new tax revenues—to assure that there are adequate subsidies to get everyone covered. So I would say universal coverage with adequate financing to make sure that comprehensive benefits are affordable to all Americans.

Ms. KURIANSKY. I think if we continue the trend now, where dependent coverage is decreasingly available and women more likely than men are dependent on health insurance through dependents coverage, we see yet another reason why universal coverage, independent of marital status, is so critical for women.

Mr. WAXMAN. Dr. Davis, you raised a point that I thought was an interesting one. If we rely on cuts in Medicare and Medicaid to finance this system, if those cuts end up being too severe, that is going to hurt women disproportionately to men. Do you feel that on the trade-off we can still come out ahead for women if we take from some women and give to others?

Ms. DAVIS. I don't think we should be financing universal health insurance coverage on the backs of the poor or just by disproportionately putting that burden on women. We know that 10 percent of women are covered by Medicaid versus 5 percent of men. We know there are 19 million women on Medicare versus 14 million men. I think the kinds of extreme budget cuts that are proposed in Medicare and Medicaid would put a burden on women, would jeopardize inadequate services, and, in the case of Medicare beneficiaries, access to care indirectly by cutting provider payment rates to a level that providers may not be willing to see Medicare beneficiaries.

Mr. WAXMAN. Well, I think the three of you have given us excellent testimony, an overview of all the matters that are before us

and how important health care reform is as a woman's issue. Thank you very much.

Ms. DOOLEY. Thank you very much, Congressman Waxman.

Mr. WAXMAN. We are going to recess now until 1:45, and we would like to have everyone back here at 1:45.

[Whereupon, at 1 p.m. the subcommittee recessed, to reconvene at 1:45 p.m. the same day.]

Mr. WAXMAN. The meeting of the subcommittee will come to order.

For our next panel I want to call forward Kate Michelman, president of the National Abortion and Reproductive Rights Action League; Jane Johnson, vice president for affiliate development and education for Planned Parenthood Federation of America. Judith DeSarno is president and CEO of the National Family Planning and Reproductive Health Association. Helen Alvaré is the director of planning and information for the Secretariat for Pro-Life Activities of the National Conference of Catholic Bishops. And Ben Mitchell is the director of biomedical and life issues of the Southern Baptist Convention Christian Life Commission.

We are pleased to welcome you to our hearing today. Your prepared statements will be in the record in full. We would like to ask, however, that you limit the oral presentation to no more than 5 minutes, and I regret to say we will have to be very, very strict about that 5-minute limitation.

Miss Michelman, why don't we start with you now that you are seated?

STATEMENTS OF KATE MICHELMAN, PRESIDENT, NATIONAL ABORTION AND REPRODUCTIVE RIGHTS ACTION LEAGUE; JANE JOHNSON, VICE PRESIDENT, PLANNED PARENTHOOD FEDERATION OF AMERICA; JUDITH M. DeSARNO, PRESIDENT, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; HELEN ALVARÉ, SECRETARIAT FOR PRO-LIFE ACTIVITIES, NATIONAL CONFERENCE OF CATHOLIC BISHOPS; AND C. BEN MITCHELL, DIRECTOR OF BIOMEDICAL AND LIFE ISSUES, SOUTHERN BAPTIST CONVENTION CHRISTIAN LIFE COMMISSION

Ms. MICHELMAN. I want to thank you for the opportunity to appear here today. And I want to begin by thanking you, Mr. Chairman, for your extremely important and aggressive leadership on health care reform in general and for your very strong support for a plan that would help end the shameful negligence toward women that has so long characterized this Nation's health care system. And how Congress shapes this plan, I believe, will profoundly affect American women and their families for generations to come.

One vital way that the President's plan addresses women's needs is by ensuring access to comprehensive reproductive health services. And that is critical because reproductive health care is primary health care for women throughout most of our lives, and women's ability to make and carry out reproductive choices is essential to their overall health and well-being and that of their families.

I also think it is important for us to understand that women, through their reproductive choices, are trying to take personal re-

sponsibility for their own and their family's futures, and I think this is an important issue. That it is not—we just don't willy-nilly make reproductive choices. It is out of our sense of responsibility, out of our sense of the role of parenting that we use reproductive choices to take responsibility. And when a woman makes a reproductive health decision to use birth control, to begin or to continue a pregnancy, to seek prenatal care, to have an abortion, to be treated for infertility, that is a profoundly life-shaping decision that only she can make.

At NARRAL, we believe that health care reform is our Nation's chance to change course, to encourage personal responsibility, to respect a woman's right to choose, but also to make abortion less necessary through preventive contraception, family planning and prenatal care.

We want the new health care plan to ensure women the ability to make those responsible decisions, not limit the choices they can make, and if the health care plan is to fulfill its promise, it must cover the full range of reproductive health services.

Private insurance plans typically recognize that abortion is integral to women's reproductive health and provide coverage for the procedure. The new national health care plan cannot do any less. Excluding abortion from the plan would be especially devastating to low-income and rural women. It would exacerbate the already severe shortage of abortion providers, and it would recklessly and unnecessarily put women and their health at risk.

It is also important for me to state that government should not be in the business of deciding which women can have abortions and which women cannot. That is not the role of government. It is the role of the woman to decide whether or not she should obtain an abortion. The new health care plan must stress prevention and provide coverage for the full range of reproductive services.

Americans are looking to Congress to act responsibly to ensure the health and well-being of women and their families. I urge you not to succumb to anti-choice political pressures and not to forget that each woman will face a range of reproductive health decisions during the course of her life.

Just a comment about this. Often, I believe, it is assumed or it is thought women's decisions are thought about in the following manner: That there is a group of women over here that uses contraception. Then there is another group that needs prenatal care. And then there is another group that needs abortions. And we can separate all of these women into neat little groups.

What I want to say about that is that we are all the same woman, that our reproductive lives span many, many, many years, and that each woman may face in her own life a series of complicated decisions about reproductive health, and we cannot divide these into neat little packages nor can we divide women as if we make these decisions in isolation from—one from another.

And, also, it is important to understand that women are more than reproducers and that when we talk about reproductive health, we have to understand that women are individuals and that reproductive health is important to our lives.

Anyway, in closing, I just say that we have an opportunity to refocus our Nation to stress prevention, health and childbirth but also to respect choice and that I hope and urge Congress to pass a bill that does all of those. Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Ms. Michelman follows:]

NARAL Promoting Reproductive Choices**TESTIMONY SUBMITTED FOR THE RECORD**

**KATE MICHELMAN
PRESIDENT OF THE NATIONAL ABORTION AND REPRODUCTIVE RIGHTS
ACTION LEAGUE
ON NATIONAL HEALTH CARE REFORM
HOUSE ENERGY AND COMMERCE COMMITTEE,
HEALTH AND ENVIRONMENT SUBCOMMITTEE
JANUARY 26, 1994**

Reproductive health care is an essential component of primary care for women and must be included in the comprehensive benefits package that will be mandated under national health care reform. No medical rationale supports the exclusion of abortion from national health care reform. According to the Association of Reproductive Health Professionals: "Advances in reproductive medicine, including access to safe, legal abortion services, have produced unquestioned health benefits for women."¹ Anti-choice politics should not be permitted to jeopardize women's health by eliminating access to legitimate and essential reproductive health services. Moreover, excluding abortion services from the basic benefits package would prove unacceptable to Americans because it would take away services currently covered under most private health insurance policies.

Abortion is an Integral Part of Women's Health Care

Assuring adequate health coverage for all Americans -- the primary goal of this effort to reform the nation's health care system -- must mean assuring that every person will have genuine access to the basic medical services that he or she may be expected to require in the course of life. For most women, reproductive health care is the major form of health care that they receive during most years of their lives. Thus, for American women, comprehensive health care coverage cannot exist without guaranteeing coverage for reproductive health care.

Different women have differing reproductive health needs, and even the same woman has differing reproductive health needs at different stages of her life. A comprehensive national health care program must provide coverage for the whole woman throughout the many stages of life. For example, at different stages of her life, one woman might need

routine gynecological exams, treatment of gynecological illnesses, various forms of contraception, and pregnancy-related treatment including pregnancy testing, prenatal care, and abortion. National health care cannot isolate one procedure for discriminatory treatment, but must assure coverage for the whole range of reproductive health care options.

Pregnancy is a health condition that requires medical attention based on a woman's individual needs, not political concerns. Care for pregnancy may involve medical services for pregnancy termination, or services to bring the pregnancy to term. Private insurance plans typically recognize abortion as integral to women's reproductive health and provide coverage for the procedure as part of pregnancy-related care.² Determining coverage for pregnancy-related medical services based upon anti-choice politics rather than on the medical needs and condition of the individual woman would severely harm women's health and well-being.

The vast majority of women require pregnancy-related medical services at some point in their lives. Most women become pregnant and more than eight out of ten will have at least one child. An estimated two-thirds of American women will have at least one unintended pregnancy in the course of their lives.³ In any single year, more than six million women become pregnant, and 3.4 million of these pregnancies are unintended.⁴ Legal abortion is one of the most commonly performed and safest surgical procedures. It entails half the risk of death involved in a tonsillectomy and one-hundredth the risk of death involved in an appendectomy.⁵ The American Medical Association recently concluded that "the risk of dying from pregnancy and childbirth has declined substantially over the past 50 years, but remains substantially greater than the risk of dying from a legal abortion."⁶ The risks of medical complications also are higher for childbirth than for abortion.⁷

All women must have the opportunity to make decisions about their reproductive health and to implement their choices through access to the full range of health services, including contraception, prenatal care and abortion. Providing coverage will ensure that women have the opportunity to make reproductive health care decisions and enable them to take personal responsibility for themselves and for their families. A health care reform program that encourages responsible decision-making by assuring access to reproductive health services will result in fewer unintended pregnancies, fewer abortions, and more healthy women and healthy babies.

Excluding Abortion Would Endanger Women's Health and Exacerbate the Current Shortage of Abortion Providers

National health care reform will significantly change the health care delivery system in this country and access to medical services not covered in the benefits package will be limited. The effect of exclusion would be particularly devastating for abortion services given the host of other anti-choice strategies being pursued to make abortion unavailable. Only women who could afford to purchase services outside the benefits package, and who could find a physician trained and willing to perform the procedure despite its exclusion from coverage, would have access to abortion. Some women who could not overcome these

substantial obstacles would be compelled to resort to unsafe illegal abortions or forced childbearing, and others would suffer delays resulting in more risky procedures. The American Medical Association in a recent study concluded that:

If national or state funding regulations . . . deter or delay women from seeking an early termination of pregnancy . . . then more women are likely to bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that would endanger their health.⁸

Forced Pregnancy and Childbearing

Some women who are denied access to abortion will be forced to carry unwanted pregnancies to term. Forced continued pregnancy subjects women to serious physical risks and burdens that range from prolonged discomfort and pain to a substantial risk of medical complications, and even death. For healthy women, the risks increase if the pregnancy was unintended and the woman is forced to carry to term against her will.⁹ Even in cases where a pregnancy is wanted and planned, the onset or worsening of a disease or medical condition may create a need for abortion. Among the medical conditions that present increased risks to women's health during pregnancy -- sometimes to the point of threatening the woman's life -- are preeclampsia, cardiovascular disease, cancer, high blood pressure, kidney disease, immunological disorders, asthma, diabetes, and AIDS.¹⁰ For many women faced with these conditions, abortion is, at times, the only procedure that can safeguard their health.

Risky Delay

Excluding coverage would increase the health risks for women who terminate their pregnancies by imposing financial and other constraints that cause risky delays. Although a first or second trimester abortion is substantially safer than childbirth, after eight weeks the risks of death or major complications from abortion significantly increase for each week of delay.¹¹ Financial obstacles often require women to delay their abortions. Approximately half of the women who obtained abortions after 16 weeks of pregnancy were delayed by the difficulties of raising money to pay for the procedure.¹² Low-income women on average obtain their abortions two to three weeks later than middle- or upper-income women.¹³ Even women of means may be forced to delay their abortions while looking for a provider. The American Medical Association recently concluded that "as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States."¹⁴

Unsafe Abortion

Any government policy that limits access to safe and legal abortion services will threaten women's health by forcing some women to resort to unsafe alternatives. Lack of insurance coverage led an estimated 2,000 women to seek illegal abortions during the first year in which federal coverage for abortion was prohibited.¹⁵ When legal abortion became

widely available in the United States as a result of *Roe v. Wade*, the number of abortion-related deaths dropped sharply and non-fatal complications of abortion diminished as well.¹⁶ Between 1972 and 1974 the total number of reported abortion deaths declined from 88 to 48, and reported deaths from illegal abortions declined from 39 to 5.¹⁷ Between 1973 and 1985 there was more than a fivefold decline in the number of deaths per 100,000 abortions.¹⁸ Women who are unable to locate trained physicians willing to provide abortion services or are unable to afford the cost of purchasing services not provided in the benefits package would be forced to turn to self-induced or unsafe, illegal abortion.

The Shortage of Abortion Providers

Excluding coverage for abortion from the comprehensive benefits package mandated under the health care reform program would also exacerbate the already severe shortage of abortion providers, further isolate physicians who perform abortions, and deter medical schools from providing training in the procedure. In 83% of counties in the United States not a single physician offers abortion services; North Dakota and South Dakota have only one abortion provider each. Anti-choice extremists across the country are using violence, threats and intimidation to pressure physicians to abandon their abortion practices. The American Medical Association concluded in a recent study that "a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions have the potential to threaten the safety of induced abortion."¹⁹ Just such a dangerous reduction in the availability of providers can be expected if the national health care package isolates and excludes abortion from the basic benefits package.

The dramatic decline in the number of abortion-related deaths after abortion became legal and available in the United States was in part due to an increase in the number of residency programs offering training in abortion procedures and training opportunities for practicing physicians.²⁰ Since 1985, however, such training opportunities have substantially decreased. The number of obstetrics-gynecology residency programs that routinely offer training in first trimester abortions declined from 23% in 1985 to 12% in 1992; the number providing training for second trimester abortions fell from 23% to 7%.²¹ Although abortion is one of the most common surgical procedures women undergo, more than one-fourth of obstetrics and gynecology residency programs offer no abortion training.²² Anti-abortion extremists are targeting medical schools in an attempt to eliminate all abortion training.²³ Excluding abortion from the comprehensive benefits package would further stigmatize the abortion procedure and diminish abortion training opportunities in the nation's medical schools.

Conclusion

A national health care reform program that based coverage for pregnancy-related

medical services on political preferences and not on the medical needs and condition of the individual pregnant woman would significantly limit women's ability to protect their health and well-being. Excluding abortion services would have the tragic effect of transforming much-needed health care reform into a dangerous and discriminatory denial of women's basic health care needs.

Endnotes

1. Amici Curiae Brief of the Association of Reproductive Health Professionals, et. al., in Support of Appellees at 12, Webster v. Reproductive Health Services, 492 U.S. 490 (1989).
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8. American Medical Association, "Induced Termination of Pregnancy," 3238.
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11. Nancy Binkin, et. al., "Illegal-Abortion Deaths in the United States: Why Are They Still Occurring?," Family Planning Perspectives, vol. 14, no. 3 (May/June 1982): 165.
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13. Stanley K. Henshaw and Lynn S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," Family Planning Perspectives, vol. 16, no. 4 (July/Aug. 1984): 170.
14. American Medical Association, "Induced Termination of Pregnancy," 3238.
15. Willard Cates, Jr., "The Hyde Amendment in Action," Journal of the American Medical Association, vol. 246, no. 10 (Sept. 1981): 1111.
16. Willard Cates, Jr., and Roger W. Rochat, "Illegal Abortions in the United States: 1972-1974," Family Planning Perspectives, vol. 8, no. 2 (Mar./Apr. 1976): 87; Michael B. Bracken, PhD, et. al., "Hospitalization for Medical-Legal and Other Abortions in the United States 1970-1977," American Journal of Public Health, vol. 72, no. 1 (Jan. 1982): 30.
17. Willard Cates, "Illegal Abortions," 87.
18. American Medical Association, "Induced Termination of Pregnancy," 3232.
19. Ibid., 3237.
20. Ibid., 3232.
21. Helene Cooper, "Medical Schools, Students Shun Abortion Study," Wall Street Journal, Mar. 12, 1993, B1.
22. Philip D. Darney, et al., "Abortion Training in U.S. Obstetrics and Gynecological Residency Programs," Family Planning Perspectives, vol. 19, no. 4 (July/Aug. 1987): 158, 161.
23. Helene Cooper, "Medical Schools," B1.

Mr. WAXMAN. Miss Johnson, do you want to pull the microphone over to you?

STATEMENT OF JANE JOHNSON

Ms. JOHNSON. Congressman Waxman, I would like to join the chorus of people representing the interests of women who talk about our gratitude for your persistence in supporting women's health and welfare issues.

I am Jane Johnson, vice president of Planned Parenthood Federation of America, and I am honored to speak today for 164 affiliates with 922 centers nationwide that make Planned Parenthood the largest private provider of reproductive health services.

Planned Parenthood's mission is to eliminate barriers to reproductive health care to all Americans and to provide care to the most vulnerable populations, including low-income women and adolescents. Seventy percent of our patients have incomes at or below 150 percent of poverty. More than 3 million patients come to us yearly for family planning, gynecological care, screening for cancer and infectious diseases, abortions, prenatal care and other clinical counseling and educational services. Another 2 million benefit from our education and training programs.

On behalf of our affiliates and the patients we serve I would like to applaud the Clinton administration and all who are working with it for addressing the critical need for health care reform. We are submitting, as you know, a longer statement.

First, Mr. Chairman, I am compelled to discuss the importance of expanding and preserving care for vulnerable populations, those persons whose health is most at risk for reasons of age, race, economics, geography, sociology, language or literacy. It is essential that the plan create no new barriers such as an unaccustomed negotiation through an HMO or health plan. Disruption in established care can doom the rightful objectives of increased access to prevention services.

We applaud the plan's designation of essential community providers for family planning clinics that receive title X funds, but in your State, Mr. Chairman, many of the best providers of family planning to low-income women rely merely upon State funds, not title X. It is important not to exclude others who furnish critical care to vulnerable populations. Community providers who receive significant public health funds, State or Federal, who serve low-income patients, should automatically be deemed essential community providers.

It is equally essential, we believe, that reproductive health services be continued categorically until it is demonstrated that integrated plans serving vulnerable population is fully up and running. We believe the plan to phase out these designations after 5 years is unrealistic and urge the committee to extend that limit.

Among the most vulnerable populations needing reproductive health care is adolescents, for whom the greatest barrier to getting pregnancy avoidance services often is the fear of disclosure. The Health Security Act addresses the confidentiality of the medical records which is essential as a first step. However, to make real the all-important ability of all patients to receive confidential care, the legislation must make certain that the mechanics of coverage

such as billing and reimbursement not sabotage patients for whom assurance of confidentiality directly determines the utilization.

Any practice that places American adolescents more at risk of unintended pregnancy or a sexually transmitted infection would be a disastrous setback of an objective of an improved health care system. Initiatives in the Act to establish school-based or school-linked services, on the other hand, we recommend be confidential and include the provision or referral for the full range of reproductive services consistent with public health objectives.

Next, Mr. Chairman, is the issue of covered services. To its credit, the comprehensive benefit package outlined in HSA proposes universal coverage of preventative reproductive health services which, for most women, constitutes the bulk of their health care needs. As you know, Mr. Chairman, this kind of preventative care has not been supported by private health insurance despite its documented cost effectiveness.

Ill-advisedly, the administration plan requires copayments and deductibles for these services. In contrast, Congress has placed a high priority on enabling women to avoid unintended childbearing, which is why there is a 90 percent federally matched family and planning services under Medicaid and why Congress wisely resisted efforts by prior administrations to water down the categorical title X family planning program.

Consistent with that history I urge the question to broadly define family planning services as they are framed under title X and to make access to those drugs, services and devices exempt from copayments and deductibles as it does with prenatal care. Both services are key to the health of women and children, and neither is susceptible to overutilization.

And because contraceptives sometimes fail, we urge the question to follow the President's lead and keep abortion in the plan.

In closing, let me say that we commend the efforts of the administration and those who work with them to move further. When we have adequate family planning, Mr. Chairman, then and only then can all Americans thoughtfully contemplate when and if to parent, the most important decisions human beings are called on to make.

Thank you.

Mr. WAXMAN. Thank you very much, Miss Johnson.

[The prepared statement of Ms. Johnson follows:]

STATEMENT OF JANE JOHNSON

Mr. Chairman, and members of the Subcommittee on Health and the Environment, I am appearing on behalf of Dr. Pamela Maraldo, President of Planned Parenthood Federation of America. The mission of Planned Parenthood is to provide access to comprehensive reproductive health care to all Americans, and especially to the most vulnerable populations, such as low-income women and teenagers. With its 164 affiliates operating 922 clinics nationwide, PPFA is one of the nation's larger health care networks, with more than three million patient visits each year for family planning, well-woman gynecological care, screening for cancer and infectious diseases, abortion, other pregnancy-related care, and other services. Nearly two million others benefit from outreach and education programs operated by our affiliates.

Real access to health is a multifaceted concept that includes making care available when needed regardless of a patient's income or geographic location. Yet, ensuring true access also necessitates lowering social barriers and guaranteeing access to confidential care delivered by a provider a patient can trust. Planned Parenthood affiliates are pledged to address all these facets of guaranteeing access to reproductive health care services.

On behalf of our affiliates and the patients we serve, I would like to applaud the Clinton administration, and all who are working with it, for addressing these important and very difficult issues.

Crucial improvements that would be made by the Health Security Act

In terms of ensuring the accessibility of health care services in general in this country, passage of the Health Security Act (HSA) would be a giant step forward. The legislation would ensure coverage for all legal residents of the United States, a long-sought goal. Even further, the plan would ban limits on coverage of pre-existing medical conditions as well as the imposition of waiting periods before coverage commences. Together, these two steps would greatly improve the lives and increase the security of millions of Americans who live in fear that illness can wipe out the life's work of entire families.

Further, the legislation would greatly improve coverage of reproductive health care for many in several ways. First and foremost, HSA would greatly expand coverage of preventive health care services, a category of health care that traditionally has been excluded by many private health insurance policies. Preventive services are key to our common goal of improving health status in this country.

To its great credit, the comprehensive benefit package outlined in HSA would include

coverage of family planning services, although what would be included under that rubric remains somewhat unclear. Abortion services are also implicitly included in the comprehensive package that all health plans would be required to offer.

Further, the legislation would require all health plans to make all covered services available to all its enrollees. According to HSA, "each health plan must enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan." This would mean that a plan in which none of the participating physicians is willing to provide abortion services, for example, would be obligated to refer women elsewhere for the services, and pay providers for their care. Both regional health alliances and states would be able to "de-certify" health plans that fail to make all mandated services available.

Second, HSA explicitly covers "services of health professionals," a term that acknowledges the vital role played by such nonphysician providers as nurse midwives and nurse practitioners in the delivery of high-quality and affordable reproductive health care. Under the plan, states would be prohibited from adopting arbitrary bans on the provision of services by nonphysicians, and would be limited to those restrictions that could be justified by the "skill and training" of providers.

A third major innovation that would be made by HSA is the acknowledgement of nonmedical services. Under the plan, "consultation" is specifically listed as a covered health professional services. Further, health care plans would be permitted, but not required, to offer health education classes. These related services -- counseling, education and information programs -- are vital to ensuring the ability of patients to obtain and utilize reproductive health care services effectively.

Last, we applaud the HSA's recognition of recipients of funds under the Title X national family planning program as "essential community providers." The recognition afforded these providers will allow them to continue to play a vital role in the delivery of reproductive health care services to the most vulnerable populations as we move together into this new era. The designation as essential providers will also allow these providers to continue to provide an avenue for direct access to needed services for patients, without always securing the consent of a gatekeeper, a possibly difficult, time-consuming and sometimes unnecessary intermediate step that could serve as an obstacle in the path of some needing care. Further, these providers would be able to continue to serve as a source of confidential care for patients -- including teenagers, spouses and others -- who would be unwilling to seek care under different circumstances.

Continuing Concerns

Despite these acknowledged and important improvements that would be made, HSA raises several unanswered questions and leaves some important gaps in its coverage of

comprehensive reproductive health care. While the plan delineates the contents of a mandated benefit package, several key details remain unclear.

- Covered services

A major concern involves coverage of family planning services. Under the rubric of "family planning services and services to pregnant women," HSA explicitly includes only "voluntary family planning services" and devices that are subject to FDA approval. The prescription and nonprescription drugs that are vital to family planning are not mentioned. According to several participants in the formulation process, nonprescription methods -- such as contraceptive jelly and foam -- would not be covered under the plan at all. Prescription drugs, such as oral contraceptives, which are used by 31 percent of contraceptive users, or nearly 11 million nationwide, would be covered but under the category of outpatient prescription drugs rather than family planning services.

This is problematic for three reasons. First, the high cost of the overall prescription drug benefit inevitably will lead some to seek its removal from the plan, or a drastic curtailment of its scope. Second, anecdotal reports appear to indicate that some current private insurance policies that cover prescription drugs nonetheless do not include coverage of oral contraceptives. Thus, coverage of oral contraceptives under the prescription drug cannot be ensured unless that inclusion is specified in the plan.

Last, under the higher cost sharing plans that would be offered under HSA, the prescription drug benefit would be subject to a separate deductible of \$250, leaving a family planning patient having to meet two deductibles before coverage commences. This could easily become an insurmountable obstacle to many patients, and could in fact lead some patients to choose a less effective or less appropriate method of contraception.

In order to offer meaningful coverage of family planning services, including a method such as oral contraceptives -- which is widely used and extremely effective in preventing unintended pregnancies -- the definition of covered family planning services needs to be broadened to include coverage of contraceptive drugs, devices and supplies. In crafting such a definition, I suggest the Congress look to a program very familiar to this subcommittee, Title X of the Public Health Services Act, which is the primary federal family planning program. The guidelines drafted by the Public Health Service for that program uses this definition:

"... Medical services related to family planning (including physician's consultation, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive drugs and devices."

In addition, the program calls for social services related to family planning and ancillary services which may be needed to facilitate clinic attendance.

A further problem in the comprehensive benefit package spelled out in the legislation occurs in its treatment of sexually transmitted diseases and infections. With no explanation, the legislation opts not to use the traditionally used term "STDs," choosing instead a new, and as yet undefined, term, "fertility-related infectious illness." Use of this term poses two potential problems. First, the only women eligible for annual screening for chlamydia and gonorrhea would be "women who have reached childbearing age and who are at risk of fertility related infectious illness." Whether this would be interpreted, in actual use, to permit annual screening for all women of childbearing age is not known. If the term is narrowly interpreted, annual screening would depend on whether an individual is designated as being "at risk," a designation that could be interpreted by some as having a pejorative connotation.

In addition, not all sexually transmitted diseases can be considered to be "fertility related infectious illnesses." Such a term could preclude routine screening for conditions such as syphilis, a step that would have clear and dangerous public health ramifications. To offer coverage for all these important public health problems and to provide screening for all these conditions for all in need, the legislation should offer routine screening for all sexually transmitted diseases and infections for all sexually active men and women.

Included among the unanswered questions that must be resolved is the question of coverage of mammograms for women under age 50. We hope that coverage for mammograms would be made available to all women for whom the procedure can be considered efficacious.

As the term "family planning services" is not fully defined in the legislation, neither is the term "services for pregnant women", an unfortunate move that leaves the inclusion of abortion services implicit rather than explicit. It appears that abortion is already covered in most health insurance plans available to private employees today. Certainly it should be covered in any national plan.

A separate problem is raised by the scope of the maternity care services that would be covered for pregnant women. Under the current construct of the bill, the expanded benefit package that was made available to low-income pregnant women in most states as a result of the Medicaid expansions of the 1980s would be limited to women who are eligible for cash payments under Aid to Families with Dependent Children (AFDC). These important expanded benefits might not be made available to low-income women who are ineligible for AFDC, including low-income women with incomes above the extremely low state-set AFDC levels or low-income women pregnant with their first child.

- Importance of confidentiality

A guarantee of confidentiality is crucial to the delivery of reproductive health care services, and a guarantee of confidentiality is vital to the development of a relationship

of trust between a patient and a reproductive health care provider. While the HSA does address the very important issue of confidentiality of medical records -- a significant concern given the development of the simplified and uniform systems contemplated by the plan -- equal attention is not given to issues regarding the delivery of confidential medical services. These issues are crucial to reproductive health care services, because of the need for teenagers, as well as other family members, to receive confidential care. Any insurance mechanism in which enrollment, billing or reimbursement is based on a family unit raises important confidentiality concerns that must be addressed to ensure that all individuals, including teenagers as well as spouses, will be willing to seek out and receive needed care without necessary delays.

However, to make the all-important ability of patients to receive confidential care a reality, the legislation must include explicit provisions guaranteeing that the mechanics of coverage, such as billing and reimbursement, not act as barrier to patients needing confidential services.

- Essential community providers

As mentioned above, we applaud the designation of recipients of Title X funds as essential community providers. Title X grantees are a vital part of the existing network of community based providers that provide direct, low-cost and confidential care to millions of patients, including many of this nation's most vulnerable populations. However, to make our common dream of unimpeded access to care a reality, the provisions concerning essential community providers must be broadened to include family planning providers funded by Title XX of the Social Security Act, the Social Services block grant, that are a major source of family planning services in many locations nationwide. In addition, where states have made major contributions to subsidized family planning services, as, for example, in California, state-funded programs should be deemed essential providers, perhaps in cooperation with national organizations that oversee their medical standards and monitor the populations served.

- Cost-sharing provisions

In line with both the emphasis of the plan on the accessibility of preventive care and oft-repeated claims by the administration that the HSA emphasizes family planning services as a way to reduce unintended pregnancy and the need for abortion, the plan should place no cost-related obstacles in the paths of patients seeking care.

It is vital that family planning be recognized in the legislation as the vital preventive health care service that it undeniably is. Congress has recognized this in the past by reimbursing the states for Medicaid family planning services at a 90% match rate, and by passing and preserving a categorical federal family planning program, Title X of the Public Health Services Act. In line with the overarching goal of the legislation to encourage rather than discourage the receipt of preventive services, family planning,

along with prenatal and postnatal care, must be exempt from any cost-sharing that could place an impediment in the path of patients seeking these vital services.

Copayments would pose a particular hardship for women who had been eligible for Medicaid under the so-called Medicaid expansions based solely on their income rather than their eligibility for welfare. These women would have been eligible for family planning services during the 60-day postpartum period with no copayments (since the Medicaid statute specifically prohibits the imposition of copayments for family planning services). These women would now find themselves subject to copayments that could cause them to delay, or even forego, obtaining the care they need.

Another provision of the legislation that could put covered services out of the reach of many is the requirement that most families contribute to the cost of the coverage itself by paying a share of the insurance premiums. Again, many women currently covered by Medicaid as a result of the Medicaid expansions could be extremely hard hit by these provisions. These expansions require states to provide Medicaid coverage to pregnant women with incomes up to 133 percent of poverty nationwide, and give states the option to offer coverage to women with incomes up to 185 percent of poverty. Under the HSA, pregnant women with incomes between 150 percent of poverty and 185 percent (as is the case in 22 states and the District of Columbia) would lose publicly subsidized care entirely; pregnant women with incomes between AFDC levels and 150 percent of poverty would face a greatly reduced public subsidy. Families in these income brackets could be hard-pressed to make these payments and could be forced to make difficult tradeoffs that are not always in the interest of their children in order to do so.

- Public health initiative

Planned Parenthood applauds the concept behind the Administration's proposed set of public health initiatives, and is especially pleased to see such a strong focus on preventive health care, a set of services we have long recognized as crucial and deserving of public support and recognition. We are pleased by the recognition of the importance of services to teenagers as indicated by the plan to establish school-based health services. The importance of offering needed, confidential care to these teenagers cannot be overstated. We urge the Congress to insure, however, that school-based or school-linked providers must offer or refer for the full range of services contemplated in the benefit package.

While we support the concepts underlying these initiatives, we have several concerns about the implementation of these plans. First, we hope that the implementation of these plans will not result in a diminution of public support for already existing community based public health providers, such as family planning clinics. As acknowledged by their designation as "essential community providers," these clinics play a vital role, and a role that is likely to continue long after the enactment of the Health Security Act, as providers of confidential care to vulnerable populations such as

teenagers, low-income patients, noncitizens and others with special needs.

Second, while we understand the intention behind the recommendation that this special community provider status sunset in five years, we think the reality is that it will take longer to have these programs fully up and running. To be sure that no one falls through the cracks in this tooling up period, we urge the extension of that expiration date to at least 10 years.

Finally, it is vital that the categorical grant programs supporting these essential providers -- including not only the Title X family planning program but also programs supporting community and migrant health centers, HIV programs, and other community-based health care providers -- be continued as such, rather than transformed into block grants, a change that would leave these programs -- and these essential providers -- subject to the uneven degrees of commitment existing in different states. Only the continuation of these programs will allow these providers to continue to be there to provide the populations in need, as well as others who are not covered under the guarantees offered to citizens in the HSA, with appropriate, sensitive and confidential care.

In closing, let me say once again that we applaud the efforts of the administration and all who worked with them to move us farther down the road toward comprehensive health care reform than we have ever been before. We look forward to working with the administration and Congress to make this common dream a reality, and to ensure that all individuals in need have complete and unfettered access to the appropriate and comprehensive array of reproductive health care that is a vital component of overall health care.

Mr. WAXMAN. Miss DeSarno.

STATEMENT OF JUDITH M. DeSARNO

Ms. DESARNO. Mr. Chairman, my name is Judith DeSarno, and I am president and CEO of the National Family Planning and Reproductive Health Association. NFPRHA represents the full spectrum of publicly funded family planning providers which include over 4,000 clinics serving more than 4 million women and adolescents annually.

We are pleased that the Health Security Act recognizes that there is nothing more fundamental than the right and ability of a woman to determine when and whether to have a child.

Our first concern is the notable absence of the coverage of contraceptive supplies. While supplies such as oral contraceptives may be covered under the section prescription drugs, we are reluctant to make this assumption because the pill is the most popular and often the most expensive method of birth control in the United States. And if the pill is approved for sale over the counter the loss of coverage could put this choice out of reach for many poor women, certainly not the intent of the authors of this bill.

We object to failure to classify family planning services as clinical prevention services which are exempt from copayments and deductibles. Even the poorest women, those who now receive free services and supplies at title X clinics would be expected to contribute to the cost of family planning services.

For our clients, most of whom are not eligible for AFDC or SSI, the minimum payments would be \$10 per visit and \$5 per prescription. While this may not seem burdensome, it would be a significant price for the poor women we traditionally serve.

Even for middle-income women, these cost-sharing requirements would serve as powerful deterrents. Women enrolled in a high cost-sharing plan would pay 20 percent of the cost of the family planning visit, 20 percent of the cost of prescription drugs or devices and would have to meet a \$250 deductible for prescription drugs.

For women who would like to use Norplant, Depo-Provera or the pill, these costs could add up to several hundred dollars, a significant disincentive. We fervently believe the failure to acknowledge the preventative nature of family planning denies women unfettered access to those services which determine the most fundamental decisions we make in our lives, decisions about childbearing.

Given the high cost of unintended pregnancy, this decision to require cost savings is shortsighted. It also undermines this administration's stated support for family planning. Tim Wirth, States Department counselor, recently stated by the year 2000 family planning services should be available to, quote, every woman in the world who wants them. The Health Security Act must guarantee no less.

We are pleased that title X clinics have been designated as essential community providers under the plan and that women will be able to receive services at title X clinics without gatekeeper approval. However, the provision does not capture the universe of providers of family planning services to low-income populations. Many clinics that do not receive title X funds do receive the bulk of their funding from other public source else, such as States or

title XX. Therefore, it would be appropriate to extend the essential community provider designation to those clinics which receive public funds and provide services to low-income populations.

We also are skeptical that the 5-year transition period will be sufficient to effectively integrate our clinics into a reformed health care system. Title X is a health care program that should serve as an example of what should be preserved and assimilated in the reform process, and we salute you, Mr. Chairman, for making certain that it has, in fact, been preserved.

Our skepticism comes in part, however, from our recent experience with the transition to managed care by many State Medicaid programs. In a number of States which have been granted R&D waivers enrollees in Medicaid managed care have been denied the option of receiving services at title X clinics. This is a direct contradiction of the intent of the essential community provider provision.

Little good will result from providing translation or transportation if access to basic health services is reduced.

Our final concern relates to confidentiality. The act fails to acknowledge that reproductive health services are sensitive and require special protection. We are especially concerned about confidentiality of services for adolescents whose parents may not know that they are sexually active, spouses who are seeking confidential services, and victims of sexual abuse and incest.

The cost-sharing requirements of the bill may also compromise confidentiality of reproductive services.

I would like to stress that title X clinics have been providing high quality, cost effective, and confidential family planning services for over 20 years. It makes sense to build on this foundation.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you for your testimony.

[The prepared statement of Ms. DeSarno follows:]

STATEMENT OF JUDITH M. DeSARNO

Mr. Chairman, members of the Subcommittee, my name is Judith DeSarno and I am President and CEO of the National Family Planning and Reproductive Health Association. NFPRHA represents the entire spectrum of family planning providers, including state and local health departments, hospital-based and freestanding clinics, Planned Parenthood clinics, and family planning councils. On behalf of the more than 4,000 publicly funded family planning clinics we represent, and the more than four million women and adolescents these clinics serve annually, I am pleased to appear before you today.

In its first year, the Clinton Administration demonstrated its commitment to family planning in general and to the Title X program in particular. The infamous "gag rule" was suspended and funding increases were proposed for both domestic and international family planning programs. Most importantly, however, was this Administration's commitment to support a health plan defined by access to universal, affordable, and comprehensive services for all Americans. These are the principles that NFPRHA has advocated for over twenty years.

We are particularly pleased that the Health Security Act recognizes that there is nothing more fundamental than the right and ability of a women to determine when and whether to have a child. It does so by mandating coverage for a broad, although not complete, array of reproductive health services. Specifically, the Act as currently drafted mandates coverage for "voluntary family planning services", services for pregnant women, and prescription contraceptive devices. However, notably absent is any mention of contraceptive supplies. While supplies such as oral contraceptives may well be covered under the general provision dealing with prescription drugs, we are reluctant to make such an assumption, particularly given the importance of covering the most popular and often the most expensive method of birth control in the United States--oral contraceptives. Further, the

current syntax could also pose a problem in the event that oral contraceptives are approved for sale over the counter. As currently drafted, the plan would not cover over the counter oral contraceptives, despite the fact that the additional cost to poor women would put this choice out of reach--something which was certainly not the intention of the authors of the bill.

We also object to the failure to classify family planning services under the rubric of "clinical preventive services," which are exempt from copayments and deductibles. In the Clinton health plan, preventive services are those which are so essential both to individuals and to society as a whole that it is inappropriate to allow even the smallest financial barrier. Mr. Chairman, we fervently believe that the failure to acknowledge the essentially preventive nature of family planning translates into a failure to offer women unfettered access to those services which determine the most fundamental decisions we make in our lives -- decisions about childbearing. Given the dramatic costs associated with unintended pregnancy and particularly unintended teenage pregnancy, the decision to require copayments and deductibles seems pennywise and pound foolish. Further, it is critically important that we recognize and by our official actions emphasize the importance of family planning.

Because family planning services are not classified as "clinical preventive services", they will be subject to copayments and deductibles. Even the poorest women--those who now receive services and supplies at no charge at Title X clinics--will be expected to contribute to the cost of family planning services after health care reform is implemented. For our population, most of whom are not eligible for AFDC or SSI, the minimum payment would be \$10 per visit and \$5 per prescription. While to most this may not seem burdensome, it could

be a significant price for the poor women we traditionally serve. Even for middle income women, the copayments and deductibles could serve as powerful deterrents to seeking needed services. For example, women who are enrolled in the high cost sharing plan would be required to pay 20 percent of the cost of the family planning visit, in addition to 20 percent of the cost of prescription drugs or devices. In addition, there is a \$250 deductible for prescription drugs in the higher cost sharing plans. Thus, for women who would like to use Norplant, Depo-Provera, or oral contraceptives, these costs could add up to several hundred dollars--a significant disincentive.

Mr. Chairman, we also have serious concerns about the essential community provider provision of the bill. We are pleased that Title X clinics are considered to be "essential community providers" under the Plan, and feel confident that this provision will ensure that women will be able to receive services at Title X clinics without gatekeeper approval. However, the provision as drafted does not capture the universe of providers of family planning services to low income populations. Many clinics that do not receive Title X funds do receive the bulk of their funding from other public sources such as states or the Title XX Social Services Block Grant. For example, in California, the state provides more funding for family planning services than does the federal government and in Texas, family planning services are funded largely by Title XX. Therefore, it would be appropriate to expand the essential community provider designation to those clinics which receive public funds and provide services to low income populations.

We also are skeptical that the five year transition period will be sufficient to effectively integrate our clinics into a reformed health care system. Congress has preserved

the Title X program for over twenty years, often in opposition to an unfriendly Administration -- a fine achievement. It is a health care program that should serve as an example of what should be preserved and assimilated in the reform process. Our skepticism, however, comes in part from our recent experience with the transition to managed care by many state Medicaid programs. In an ever increasing number of states which have been granted Section 1115 research and demonstration waivers, enrollees in Medicaid managed care have been denied the choice of Title X clinics as their service site. This move seems to be a direct contradiction of what the essential community provider provision seeks to do.

Further, the bill does not assure that categorical funding will continue over this same five year period and not taper off prior to the full integration of the clinics into the overall managed care system. This is particularly problematic given that the Title X system is already far less extensive than it needs to be in order for the underserved to have universal access -- a result of severe budget cuts in the early 1980s. The shortage of clinics in our system is evident when you look at an area such as South Central Los Angeles, the site of extreme poverty and high rates of unwanted pregnancies -- yet, there isn't a single Title X clinic in that vicinity --although we know that this Committee and Representative Maxine Waters are working to remedy that situation. However, it does point to the tremendous unmet need for family planning services in low income areas. Thus, it is critical that categorical funding for Title X not be prematurely diminished or shifted into the pool designated for "enabling services" during the transition. While we consider "enabling services" to be an important component of health care reform, it does little good to offer translation and transportation services in the absence of health services.

The final concern that we would like to address today is confidentiality--a cornerstone of the Title X program. The Health Security Act fails to acknowledge that reproductive health services are "sensitive" and require special protection. While the bill generally guarantees privacy of information and prohibits unauthorized disclosure of any individually identified information, it does not explicitly preclude notifying parents that a minor son or daughter has received a reproductive health service. We are especially concerned about services for adolescents whose parents may not know that they are sexually active, spouses who are seeking confidential services, and victims of sexual abuse and incest. The fact that copayments and deductibles are required because family planning services are not considered "clinical preventive services" may also compromise confidentiality of reproductive health services.

In closing, I would like to emphasize that Title X clinics have been providing high quality, efficient, effective, low cost, and confidential family planning services for over twenty years. It only makes sense to build on this foundation as our system is refashioned.

Timothy Wirth, State Department Counselor, recently expressed the Administrations goals for family planning--saying that, by the year 2000, family planning services should be available to "every woman in the world who wants them." The Health Security Act must guarantee no less. We are looked to as the global leader on issues of family planning and reproductive health. We must not have a double standard for Americans who both need and want access to the full range of family planning services. Therefore, we urge the Administration and Congress to take appropriate action to make sure that this goal is realized. Meaningful access to family planning services and supplies -- that is, with no informational, financial, or geographic barriers -- must be our collective goal. The Health Security Act goes a long way toward this objective -- and with the improvements suggested here today, we could begin to meet this challenge in our country. I would be happy to meet with you to discuss more specific ways in which these objectives can be met. Thank you.

Mr. WAXMAN. Ms. Alvaré.

STATEMENT OF HELEN ALVARÉ

Ms. ALVARÉ. Hello. My name is Helen Alvaré.

I am here on behalf of the Catholic Bishops of the United States. I thank the committee for the invitation to testify today.

The Catholic Church's support for health reform—especially for universal coverage and special attention to the needs of the poor—goes back 75 years. We are also a major provider of health care—last year serving 45 million people in our hospitals and facilities, and delivering over half a million babies. We are also the largest provider of social services in the United States to women of any private provider.

We believe that the fundamental right to health care is grounded in the right to life, a right of all human beings regardless of age, sex, or condition of dependency. True health care reform, therefore, could never promote attacks on life itself. Tragically, the administration's plan, and some others, by including abortion as a mandated benefit, undermine health reform at its root and would assault the consciences of millions of Americans who understand that abortion destroys human life.

Conscience clauses protecting providers from performing abortions are certainly welcome but they don't resolve the problem. So long as abortion is a mandated benefit, Americans would be forced to subsidize abortions, and in a dramatic change regional health systems would have to insure women ready access to abortion were it a mandated benefit. And even more fundamentally, the Federal Government would be in the position of treating the unborn child as a "patient"—by covering prenatal care and medicine—and at the same time affirming that the patient may be deliberately killed by another covered service, abortion. And how can the plan call infertility a disease, and at the same time say the same of fertility and use abortion as the cure for that? We might as well say that.

Including abortion coverage also makes no sense from the perspective of women's health. Pregnancy is not a disease requiring a "cure." (I am not ill because I am pregnant). Treating abortion as a medical "cure" reflects a sexist attitude that when a woman has a gift men do not possess, it must be a "disease."

The Alan Guttmacher Institute, an abortion advocate, confirms that the vast majority of abortions are performed for reasons completely unrelated to a woman's physical or even psychological health. They complain in fact in their 1993 Health Care Reform report that insurers often treat abortion as purely elective. But elective abortion, abortion purely as a matter of private choice, has been the long time battle cry of abortion advocates. Now, they want it to be considered a "health" matter. And they have not hesitated to burden the entire momentum for health care reform with their agenda: All the public will be forced to pay for what they have always called a "private choice", a choice which they want women to be able to make "electively."

We are not alone in noting that abortion is not an integral part of women's health care. The Supreme Court gave us *Roe v. Wade* conceded that abortion is not like any other medical procedure, because, as they said, no other involves "the purposeful termination

of a potential life." Most hospitals and doctors won't do abortions. Most medical students don't train for it. Abortionists testify publicly to their ambivalence about their practice and how they are shunned by the general medical community.

Abortion advocates want to break out of this ghetto, make abortion somehow a respectable "health" or medical service, but Americans are not buying this narrow agenda. Poll after poll shows they do not want to be accomplices in abortion; they do not want to pay for others' abortions. This opposition is particularly strong among low-income women and racial minorities, whom, surprisingly enough, abortion advocates claim to represent but cannot. Support for tax-funded abortions comes disproportionately in fact from those who are wealthier, white, and male.

Some want to include abortion under the rubric of family planning services. This rubric has problems of its own, since contraception and sterilization are themselves elective procedures curing no illness and sometimes having serious health threatening effects of their own. More importantly, abortion does not help plan families—it destroys a developing member of the family. As Planned Parenthood used to acknowledge in their brochure 30 years ago: Abortion is not birth control because "abortion kills the life of a baby after it has begun." Abortion in family planning programs even undermines those programs' goals as it tends to replace preventive measures; when abortion becomes part of family planning, unintended pregnancies go up.

As Kate Michelman, who testifies here today, has said publicly, "Abortion is a tragedy. Abortion is a bad thing." Forcing every American to be an unwilling collaborator makes a bad thing worse. And the sooner the burden of abortion is lifted from health care reform, the better for the cause of needed reform.

Thank you.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 186.]

[The prepared statement of Ms. Alvaré follows:]

TESTIMONY OF HELEN ALVARÉ

Director of Planning and Information
 Secretariat for Pro-Life Activities
 National Conference of Catholic Bishops

Energy and Commerce Subcommittee on Health and the Environment
 U.S. House of Representatives

January 26, 1994

My name is Helen Alvaré, and I serve as a spokesperson on pro-life issues for the Catholic bishops of the United States. I want to thank the Subcommittee for inviting us to testify on the role of "reproductive health" in the health care reform debate.

It was just after World War I, in 1919, that the Catholic bishops of the United States issued their first collective statement in support of guaranteed health insurance for all Americans.¹ Since then the bishops' support for comprehensive reform has been demonstrated on numerous occasions, especially through the resolution on health care reform they adopted unanimously last June.² Just two days ago our Conference testified before this Subcommittee on the health needs of migrants and refugees, including undocumented workers. Our Conference has been especially concerned to help ensure adequate prenatal care, maternity benefits and nutritional support for mothers and children -- as evidenced by our activities in support

¹Administrative Committee of the National Catholic War Council, "Program of Social Reconstruction" (Feb. 12, 1919), para. 25; see Nolan (ed.), Pastoral Letters of the United States Catholic Bishops (U.S. Catholic Conference 1984), Vol. I, p. 265.

²U.S. Bishops, "Resolution on Health Care Reform," in 23 Origins (July 1, 1993), pp. 97, 99-102. Also see Health and Health Care: A Pastoral Letter of the American Catholic Bishops (U.S. Catholic Conference 1982).

of expanded Medicaid eligibility for prenatal care, improved funding for WIC programs, and the Family and Medical Leave Act.³

Besides being an advocate for health care reform, the Church is both a major provider and a purchaser of health care. Our 600 hospitals and 300 long-term care facilities admit over 5 million patients, provide outpatient services to over 40 million people, and deliver over half a million babies every year. Over 100,000 people receive pregnancy and adoption services from Catholic Charities agencies annually. Catholic agencies are among the grantees receiving federal funds under the Adolescent Family Life Act for programs to prevent premature sexual activity by adolescents and to provide care and social services to those already pregnant. Over 3400 pro-life "alternatives to abortion" centers, many operating under Catholic auspices or with Catholic financial support, provide free or low-cost medical, counseling and social services to women facing problems related to pregnancy. Catholic dioceses, agencies and institutions purchase health insurance for hundreds of thousands of employees, and have a deep concern over any health plan that would compromise the ethical integrity of such institutions.

Our advocacy and institutional involvement in health care are rooted in longstanding convictions about the dignity of the human person and the sanctity of each and every human life, at every stage of development from conception to natural death. As

³See: U.S. Bishops, "Putting Children and Families First: A Challenge for Our Church, Nation and World," in 21 Origins (Nov. 28, 1991), pp. 393 and 395-404, especially pp. 396 and 401-2.

Pope John XXIII observed in his encyclical Pacem in Terris, it is because human beings have a fundamental right to life that they also have a right to the means necessary to protect and nurture life, including adequate nutrition, housing and health care.⁴

Because the right to health care is grounded in the right to life, no health care reform worthy of the name should subsidize or promote attacks on life itself. To do so would undermine health care reform at its root. Genuine reform must begin from the conviction that healing, not killing, is a service owed to all human beings, regardless of age, sex or condition of dependency. As Christians committed to a preferential option for the poor and vulnerable, we would go further still. We believe reform should be judged primarily by how it treats the most marginalized and helpless members of our society: the poor, the uninsured, the undocumented and the unborn.

We therefore see health care reform legislation which includes abortion among basic "services for pregnant women" as a grave mistake. To include abortion as a mandated benefit -- one which all Americans must purchase for themselves and subsidize for others -- is to assault the consciences of millions of Americans who understand that the destruction of unborn life is the exact opposite of "health care." Regrettably, the Administration's plan (H.R. 3600) and several proposed

⁴See "Resolution on Health Care Reform," op. cit., p. 99.

alternatives to it do include abortion among basic benefits.⁵

This problem is not resolved by pointing to "conscience clauses" that may protect doctors and hospitals from having to perform abortions (e.g., Section 1162 of H.R. 3600). Such provisions are welcome, although they simply reaffirm what has already existed in federal law for two decades.⁶ But even with "conscience clauses" for providers, the health plan would still artificially inject abortion into the mainstream of health care, making it a new norm for medical practice. Physicians, nurses and hospitals who opt out of abortion would be tolerated, but increasingly relegated to their own institutional ghettos; they would face crises of conscience when trying to collaborate in larger health systems providing elective abortions. In the Administration's plan, regional health alliances would have a new mandate to ensure that all women in their area have ready access to abortion -- a sweeping change in a nation where 83% of counties currently have no abortion provider.⁷ Most importantly,

⁵See, e.g., H.R. 3600's provisions on "family planning services and services for pregnant women" (Section 1101 (a) (6), Section 1116). The bill has no abortion limitations, and explicitly prohibits "any duration or scope limitation" on such benefits "that is not required or authorized under this Act" (Section 1101 (b)). Section 1161 further provides that states may not, "through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals" -- a provision that may be used to attack state laws allowing only licensed physicians to perform abortions.

⁶U.S. Public Health Service Act, 42 U.S.C. § 300a-7 (1973).

⁷See Mimi Hall, "Legal abortions tougher to get," USA Today, May 1, 1991, p. 7A.

all Americans and all employers would still be forced to buy abortion coverage for themselves and to support the system of mandated abortion coverage through their taxes and health premiums.

Pro-abortion organizations will claim that abortion must be included so that health care reform guarantees a "full range" of reproductive or pregnancy-related services. This claim is purely ideological -- it makes no medical sense. Any adequate health care plan will cover fetal and perinatal medicine, thereby affirming that the child before birth is a physician's patient. An abortion kills that patient. Even the Supreme Court that gave us Roe v. Wade conceded that abortion has no claim to inclusion in otherwise comprehensive health programs: "Abortion is inherently different from other medical procedures," the Court observed, "because no other procedure involves the purposeful termination of a potential life."⁵

Including abortion does not even make sense from the point of view of women's health. Pregnancy is not a disease in need of a "cure." A pregnant woman may have special nutritional and medical needs, because she is supporting a second life in addition to her own; she may have other illnesses or conditions which complicate pregnancy and demand appropriate evaluation and

⁵Harris v. McRae, 448 U.S. 297, 325 (1980). The Court has also upheld state laws forbidding the use of state facilities and employees for abortions, saying that "the State need not commit any resources to performing abortions, even if it can turn a profit by doing so." Webster v. Reproductive Health Services, 492 U.S. 490, 492 (1989).

treatment of their own. But a woman who is pregnant is not ill.

We must not inject into medicine the sexist attitude that conditions peculiar to women are somehow abnormal or "diseased" because men are incapable of them. On the contrary, a woman's ability to conceive and become pregnant is an indication that she has "reproductive health." How can we call infertility a disease in need of treatment, and then call fertility a disease as well?⁹ We might as well say that because health care includes efforts to cure breast cancer it should include efforts to produce it as well.¹⁰

While conceding that abortion is generally not a therapeutic procedure, some seek to include it under the rubric of "family planning" services. This poses problems of its own. Contraception and sterilization are themselves elective procedures: they cure no illness, and many methods can have serious health-threatening side-effects of their own. Such

⁹We do strongly agree with the Administration's decision not to cover in vitro fertilization, which is not so much an infertility treatment as a laboratory procedure that substitutes for normal human reproduction. Besides being extremely expensive and generally unsuccessful, IVF is morally objectionable to us.

¹⁰This is no idle analogy: Many studies suggest that abortion of a first pregnancy significantly raises a woman's risk of having breast cancer. A recent study of breast cancer among African American women, conducted by the Howard University Cancer Center, concludes: "An increased odds ratio was found for induced abortions, which was significant in women diagnosed after 50 years of age. Spontaneous abortions had a small but significant protective effect in the same subgroup of women. Birth control pill usage conferred a significantly increased risk." Laing et al., "Breast Cancer Risk Factors in African-American Women: The Howard University Tumor Registry Experience," 85 Journal of the National Medical Association (December 1993), p. 931.

procedures have a poor claim to the status of essential health services, and they should not be forced upon employers and individuals who have moral and religious objections to them. Nor should any health plan require new federal funding for "school-based clinics" that provide contraceptives and abortion counseling to unmarried teenagers without their parents' consent.¹¹

But whatever one's view of family planning as such, we should recall that for over twenty years our domestic and foreign family planning programs have explicitly excluded abortion from "family planning" methods.¹² In part this was due to the realization that abortion does not help plan families but destroys a developing member of the family. Planned Parenthood once made this distinction, declaring thirty years ago that abortion is not birth control because "an abortion kills the life of a baby after it has begun."¹³ In part, however, Congress's exclusion of abortion from family planning programs has been based on the realization that including abortion would undermine the goals of these programs. Easily accessible abortion tends to discourage responsible decisionmaking about sexuality and

¹¹Such clinics are deservedly controversial on moral, political and legal grounds. See National Conference of Catholic Bishops, Statement on School-Based Clinics (U.S. Catholic Conference 1987). Recently a New York court ruled that such clinics violate parents' constitutional rights when they dispense condoms to unemancipated minor students without parental consent or an "opt-out" provision. Matter of Alfonso v. Fernandez, Supreme Court of New York (Appellate Div., 2nd Dept.)(No. 92-06950, 12/30/93).

¹²Title X of the Public Health Service Act, 42 U.S.C. §300a-6 (1970); Foreign Assistance Act, 22 U.S.C. §2151b(f)(1) (1973).

¹³Planned Parenthood - World Population brochure, "Plan Your Children For Health and Happiness" (New York 1963).

pregnancy; so more women become unintentionally pregnant and abortion replaces preventive methods.¹⁴ The converse is also true: When access to abortion is restricted, fewer women become unintentionally pregnant in the first place.¹⁵ In practical terms, the abortion industry's "family planning is indivisible" rhetoric is blatantly false: The abortion agenda is at war with the goal of preventing unintended pregnancies.

Of course, many pro-abortion groups ignore these medical and social facts and claim simply that abortion is a "private choice" -- that a woman must be guaranteed ready access to abortion whenever she wants one, even in the final stages of pregnancy and for any reason whatever. Such an agenda has little to do with women's health. The Alan Guttmacher Institute has confirmed that the vast majority of abortions are performed for reasons that have nothing to do with women's physical or even psychological

¹⁴When Congress barred Title X grantees from treating abortion as a family planning method in 1970 it cited this concern: Cong. Record, Nov. 16, 1970, pp. 37375-8; D. Callahan, Abortion: Law, Choice and Morality (MacMillan: New York 1970), Chapter 7. Later studies confirm this finding: K. Luker, Taking Chances: Abortion and the Decision Not to Contracept (U. of Calif.: Berkeley 1975), Chapter 1; R. Sherlock, "The Demographic Argument for Liberal Abortion Policies," in Hilgers et al. (eds.), New Perspectives on Human Abortion (University Publications of America 1981), pp. 456-60.

¹⁵"Greater restrictiveness [in state abortion laws] significantly raises the probability of carrying to term" among teens already pregnant, but "also lowers the probability of becoming pregnant...the teenagers are less likely to become pregnant in the first place." S. Lundberg and R. Plotnick, "Effects of State Welfare, Abortion and Family Planning Policies," 22 Family Planning Perspectives (Nov./Dec. 1990), p. 250. Also see J. Kasun, "Cutoff of Abortion Funds Doesn't Deliver Welfare Babies," Wall Street Journal, Dec. 30, 1986.

"health."¹⁶ This being the case, abortion would have to be described as an elective procedure -- and it is widely accepted that elective procedures have no place in the mandated benefits package of a national health plan. In fact, the Guttmacher Institute -- contrary to some claims that insurance coverage of abortion is already the norm in our country -- has complained that services such as abortion "are often described as 'elective,' and, therefore, are excluded from coverage."¹⁷ The claim that abortion is purely "elective," purely a matter of an individual woman's unreviewable choice, has been the linchpin of abortion advocacy in our nation for twenty years. It is rather late in the game for pro-abortion groups to do a 180-degree turnaround on this point in order to exploit health care reform as a vehicle for the abortion industry.

We are far from alone in pointing out that abortion is not an integral part of health care. The medical profession itself has voted with its feet on this issue. Most hospitals won't provide elective abortions, most physicians will not perform them, and most medical schools and residency programs do not offer abortion as an integral part of ob.\gyn. training; in

¹⁶In the Guttmacher study, only 7% of women having abortions cited a physical, mental or emotional "health problem" as one of the reasons for the abortion; half of this small minority said a doctor had told them pregnancy would make their condition worse. A. Torres and J. Forrest, "Why Do Women Have Abortions?", 20 Family Planning Perspectives (July/August 1988), pp. 170 and 172.

¹⁷Jeannie I. Rosoff, Health Care Reform (Alan Guttmacher Institute 1993), p. 12.

programs where abortion training is optional, attendance is low.¹⁸

This is not just because some physicians fear picketing or "harassment" from pro-life activists. As abortion practitioners themselves have testified, it is because they are not respected by almost anyone. Abortionists are ambivalent about their own distasteful task, looked down upon by other physicians, shunned by women seeking other kinds of health care, and confined largely to separate free-standing clinics whose major business is abortion.¹⁹

Understandably, the abortion industry and its political allies are seeking ways to dilute this stigma and break out of this ghetto -- hence pro-abortion groups' new rhetoric about a wider "reproductive health" agenda, and their effort to gain respectability by inserting themselves into national health care reform. But that does not mean Congress should accede to their request. In fact, this kind of special-interest advocacy is exactly what Congress should resist, so as to shape the health

¹⁸Abortion is a routine part of ob./gyn. training in only 12% of residency programs (only 7% provide instruction in second-trimester abortion); 31% do not offer abortion training at all, and participation is very low in programs that treat it as optional. J. Price, "Fewer Hospitals Provide Abortion Training," Washington Times, April 15, 1992.

¹⁹See: D. Gianelli, "Abortion providers share inner conflicts," American Medical News, July 12, 1993, pp. 3, 36-7; Dr. Jane Doe, "Why I Am an Abortionist," Glamour, Oct. 1993, pp. 240-241; Le Anne Schreiber, "Where are the Doctors Who Will Do Abortions?," Glamour, Sept. 1991, pp. 280-283, 320-321; Erik Goldman, "Perceive Established Medicine as Indifferent," Ob. Gyn. News, May 15, 1993, pp. 1-19.

care system in accord with the common good of all the people.

This is a matter on which the American people have spoken a number of times. As numerous opinion polls have shown, most Americans oppose public abortion funding, and they oppose including abortion among the mandated benefits that all insured parties must help subsidize. A survey published in the April 6, 1993 New York Times indicated that only 23% of Americans think health care reform should cover abortions, while "72% said those costs should be paid for directly by the women who have them."

Moreover, opposition to mandated public funding is strongest among those populations who stand to gain the most from genuine health care reform: low-income women and members of racial minorities. Support for such funding is strongest among affluent and educated white Americans who can easily afford good health coverage already.²⁰ If Congress is serious about reform it should look first to the needs of the poor and vulnerable, not the preferences of the rich and powerful.

Specifically, Congress should treat with great skepticism the argument that abortion is already part of the status quo in most private plans, and therefore that reform should not deny women a health "benefit" they already have. As I have already noted, pro-abortion groups' own studies point to the opposite conclusion: That abortion is often not included in private plans. This is why the abortion industry is so insistent on having the

²⁰See: Susan Mitchell, "Who Says Abortion is Murder?", American Demographics, Feb. 1993, p. 21; M. Cunningham, "The Abortion War," National Review, Nov. 2, 1992, p. 44.

government force all of us to include it and subsidize it. Recent interviews with the directors of abortion clinics confirm that theirs is primarily a cash business in which health insurance plays only a minor role.²¹ And interviews with insurance companies have confirmed what we could already guess from the opinion polls -- that where abortion coverage is included in insurance plans, this is due not to public demand or to individual requests but to the insurance companies' own unilateral decision. These companies cover abortion for fiscal reasons, because they see abortion as cheaper than childbirth.²² But the profit motives of private insurance companies should not determine Congress's policy decisions on matters of life and death.²³

As Kate Michelman of NARRAL has said, "abortion is a bad

²¹Abortion coverage "appears to be the exception in Missouri and Illinois." M. Shirk, "Abortion Inclusion in Health Plan Assures Fight in Congress," St. Louis Post-Dispatch, Sept. 24, 1993. Also see: S. Buttry, "Health Plan Sparks Fight on Abortion," Omaha World Herald, Sept. 28, 1993; D. Gianelli, "Battle brews over abortion as basic reform benefit," American medical News, Oct. 25, 1993, p. 8.

²²B. Levine, "A Belated Debate Over Abortion Funding?", Los Angeles Times, April 22, 1993, p. E1.

²³Mrs. Hillary Rodham Clinton has observed that insurance companies "like being able to exclude people from coverage because the more they can exclude, the more the more money they can make. It is time that we stood up and said 'We are tired of insurance companies running our health care system'" (Washington Post, Nov. 2, 1993). Apparently these companies also include some coverage primarily to save money, because they think every abortion saves them the cost of a live delivery.

thing."²⁴ Forcing every American to become an unwilling accomplice in other people's abortions makes a bad thing even worse.

In short, the Catholic bishops believe unanimously that it is a grave moral wrong, a serious policy misjudgment and a huge political mistake to burden health care reform with abortion. In fact, the sooner the burden of abortion is lifted from health care reform, the better for the cause of reform. Congress should enact real health care reform that protects the life and dignity of all, especially the poor and vulnerable, not legislation that destroys life and forces all of us to fund abortions.

²⁴Quoted in "Activists adopting views held by their opponents," Fort Myers News-Press, Dec. 13, 1993, p. 8A.

Mr. WAXMAN. Mr. Mitchell.

STATEMENT OF C. BEN MITCHELL

Mr. MITCHELL. Thank you, Mr. Chairman, for the opportunity to address health care reform before this subcommittee. My name is Ben Mitchell and I serve as director for biomedical and life issues for the Southern Baptist Christian Life Commission.

The Southern Baptist Christian Life Commission is based in Nashville, Tenn. and maintains an office in Washington, DC. The Christian Life Commission is the moral concerns, public policy, and religious liberty agency of the Southern Baptist Convention, America's largest non-Catholic religious denomination with 15.4 million members in more than 38,000 churches nationwide.

It will be in our written testimony that our concerns about health care in general and women's health issues in particular are rooted in our commitment to and understanding of the Scriptures of the Old and New Testaments. That is who we are.

Our denominational concern about health care reform was demonstrated most recently in a Southern Baptist Consultation on Health Care held here in Washington, DC. on January 18, 1994. As a result of earlier analyses and the health care consultation, numerous concerns emerge about the President's Health Security Act, as well as the other health care proposals which are in various states of evolution. Two documents formulated as a result of our consultation, "Health Care Reform: A Moral Preamble" and "Health Care Reform: A Statement of Concerns" will inform much of what we have to say about health care reform and is included in our written testimony as appendices. We should be clear, then at the outset of our testimony that because of our historically attested and committed opposition to public funding for elective abortion, the Southern Baptist Convention Christian Life Commission is prepared to marshal as many of our resources as necessary to oppose vigorously any health care plan that includes coverage for elective abortion. This is such a critical concern for us that we are prepared to oppose any reform which is otherwise excellent if it also includes coverage for elective abortions.

The Christian Life Commission recognizes the need for health care reform. In our view, this goal does not necessarily mandate a government controlled health care system such as a number of those being proposed at present.

So-called "reproductive rights" have been a paramount issue in discussions of women's health care issues for at least 2 decades. In most cases, "reproductive rights" has been a euphemism for abortion rights.

Southern Baptists and other Americans clearly oppose the Federal funding of abortion on demand. The most recent Southern Baptist Convention resolution on abortion, for instance, states, "We oppose the inclusion of abortion in any health care plan which may be proposed by the President and adopted by Congress and urge policy makers to protect the consciences of millions of pro-life taxpayers and employers by not forcing them to pay such a repugnant act."

Our uncompromising aversion to elective abortion arises from a three-fold concern, which we elucidate in our written testimony,

first, elective abortion violates the ethical and theological norms of the Christian faith.

Second, elective abortion violates the most respected tradition in Western medicine.

Third, elective abortion does not regard women's health as a fundamental value. The practice of elective abortion is, in fact, contrary to women's health. We are troubled by the probability that studies on the link between abortion and women's health will not be investigated adequately.

Furthermore, the President and Mrs. Clinton have made it clear that elective abortion will be part of the "comprehensive benefits" offered under "pregnancy-related services" in their plan. This, in spite of the fact that there is surprising uniformity on the question of whether or not abortion funding should be part of any potential health care reform. As we have heard already today, as many as 72, perhaps 75 percent of Americans have said abortion should not be included in the benefits package of any national health care plan. Thus, the view of Southern Baptists with respect to funding of abortion in health care reform is consistent with that of the overwhelming majority of Americans: No abortion in health care reform.

There is a fundamental difference, in deference to Ms. Schroeder earlier today, there is a fundamental difference between PSA's for men and mammograms for women and abortion in that the latter, that is abortion, results in the premeditated murder of an unborn human being.

By making abortion a requirement of the comprehensive benefits package, health care reform of the President's variety would compel every denomination and local congregation either to fund abortion or else break the law and suffer its penalties. There would be no "safe harbor." Moreover, every person motivated by religious faith to oppose abortion also would be coerced to support this immoral practice.

Every congregation as an employer would be coerced to take money from the offering plate and offer it up to abortionists. The choices would be extremely limited: Pay up and shut up or face the harsh repercussions of following religious conscience.

In conclusion let me say that last night the President was precisely correct. Americans stand at the threshold of a momentous decision concerning the kind of society this will be. We will either be a society of life, liberty and kindness, or we will be a barbarous and narcissistic society. We will regard every human being as having intrinsic worth. Or, will we make subjective, relativistic quality of life judgments about the worth of persons' lives?

Whatever our lawmakers choose to do, we must be true to our God, our convictions, and our consciences. We cannot do otherwise. We hope we will be able to stand with our elected officials for revisions and reforms in health care that will evidence our commitment to the intrinsic value of every human life.

Thank you.

Mr. WAXMAN. Thank you for your testimony.

[Testimony resumes on p. 220.]

[The prepared statement of Mr. Mitchell follows:]

Health Care Reform: Women's Health

Testimony

by

C. Ben Mitchell, M.Div. (Ph.D. Candidate)
Director of Biomedical and Life Issues

Southern Baptist Convention Christian Life Commission

before the

Sub-committee on Health and Environment

Energy and Commerce Committee

of the

United States House of Representatives

January 26, 1994

Introduction

The Southern Baptist Christian Life Commission is based in Nashville, Tennessee, and maintains an office in Washington, D.C. The Christian Life Commission is the moral concerns, public policy, and religious liberty agency of the Southern Baptist Convention, America's largest non-Catholic religious denomination with 15.4 million members in more than 38,000 congregations nationwide.

We are grateful for the opportunity to address the issue of health care reform before this body. We should note that our responsibility to

speak to health care reform is enhanced by the facts that (1) President Clinton is a member of a Southern Baptist congregation, (2) historically Southern Baptists have demonstrated their palpable concern for health care through the establishment of charitable hospitals and clinics around the world, and (3) as citizens of the United States we feel an obligation to contribute to the dialogue on this most important debate.

From the outset it will be apparent that our concerns about health care in general and women's health issues in particular are rooted in our commitment to and understanding of the Scriptures of the Old and New Testaments. Southern Baptists are known both inside and outside the denomination as a "people of the Book," and we believe without apology that the Bible is God's revelation of truth to all persons. While we are aware that our theological and philosophical presuppositions are not universally held, in order for our testimony to be candid and credible we believe we must be forthright in expressing our convictions. This is who we are.

Health Care Reform

Our denominational concern about health care reform was demonstrated most recently in a Southern Baptist Consultation on Health Care held in Washington, D.C. on January 18, 1994. As a result of earlier analyses and the health care consultation, numerous concerns emerge about the President's Health Security Act (H.R.3600; S.1757), as well as the other health care proposals which are in various states of evolution. Two documents, formulated as a result of our consultation, "Health Care Reform: A Moral Preamble" and "Health Care Reform: A Statement of

Concerns" will inform much of what is said below (see Appendix A). Furthermore, Southern Baptists have a rich and developing literature on bioethics and health care issues, especially with respect to the sanctity of human life.

Let it be clear, then, at the outset of our testimony that because of our historically attested and committed opposition to public funding for elective abortion, the Southern Baptist Convention Christian Life Commission is prepared to marshal as many of our resources as necessary to oppose vigorously any health care plan that includes coverage for elective abortion. This is such a critical concern for us that we are prepared to oppose any reform which is otherwise excellent if it also includes abortion on demand.

Southern Baptists speak to moral, public policy, and religious liberty issues through two principal vehicles. First, the Southern Baptist Christian Life Commission has been charged with the assignment of making known to our elected officials and legislative bodies the concerns of our denomination's over 15.4 million members. Second, the Southern Baptist Convention meets annually, at which time resolutions are adopted in business sessions. These resolutions are statements which are meant to inform others of our views on a variety of important issues.

The Christian Life Commission recognizes the need for health care reform. Ultimately, we believe the benefits of health care should extend to all humanity. We favor responsible measures to reduce the amount of unnecessary medical care and procedures. Furthermore, we are prepared to advocate efforts to liberalize access to health insurance and acceptable means to ensure that all American citizens have access to necessary medical care. These goals do not necessarily mandate a government

controlled health care system such as a number of those being proposed at present. As Baptists we are committed to our forebear's insistence on limited government as exhibited in the Constitution of the United States. Government, often with the best of intentions, sometimes breeds unnecessary bureaucracy, complacency, insensitivity, and woeful ineptitude. We are concerned that, in the end, the health care delivery system is improved and not destroyed.

We, therefore, insist that efforts to reform our present health care system be afforded the utmost in careful analysis and measured change. The reform of the American health care system will be, perhaps, the most monumental and far-reaching social policy change of this century. Such pervasive social reform demands the best efforts possible. The costs, measured both in terms of economics and human well-being, of a failed experiment of this sort are too great a burden to bear. We must "get it right" the first time.

The fact that 562 economists, many of them world-renowned scholars, including Stanford University economist Alain C. Enthoven, have called upon President Clinton to remove price controls from the Health Security Act serves as a warning that health care reform must be approached extremely cautiously. Otherwise, social and economic disaster could result.¹

Women's Health

¹"Dear Mr. President . . .," *The Wall Street Journal*, 1/14/94. Also, Robert Pear, "Warning on Health Plan from Author of the Idea," *The New York Times*, 1/13/94.

So-called "reproductive rights" have been paramount in discussions of women's health care issues for at least two decades. In most cases, "reproductive rights" has been a euphemism for abortion rights.

Southern Baptists in general and the Christian Life Commission in particular firmly believe elective abortion is unacceptable both as a medical procedure and as public policy. For well over a decade the overwhelming majority of Southern Baptists, along with the majority of Americans, have opposed the federal funding of abortion on demand. Southern Baptist Convention resolutions adopted in 1980, 1982, 1984, 1989, 1991, and 1993 affirm that the imminent death of the mother is the only ethically just exception to the prohibition of the federal funding of abortion (see Appendix B for examples).

Our uncompromising aversion to elective abortion arises from a three-fold concern. First, elective abortion violates the ethical and theological norms of the Christian faith. The sanctity, sacredness, or intrinsic value of every human life forms the heart of biblical anthropology. When we distill the controversy over abortion, euthanasia, genetic manipulation, fetal tissue use, etc., the common essence is the violation of the sanctity of human life. Are human beings the unique creations of God? Is human life sacred and inviolable?

Some researchers and ethicists argue that the developing embryo in a mother's womb is merely a "glob of tissue" and of no more value than the embryo of a guppy. The issue is, then, whether or not human life is unique, sacred, and worth protecting.

The question that keeps ringing in the ears of those who are committed to a biblical world view is: "What does the Sovereign Lord, the giver and creator of life, have to say about the value of human life? What

does God have to say through His Word, the Bible?" This is where we must begin.

The sanctity of human life is rooted and grounded in the Creator Himself. Many biblical texts affirm that humans are the special creation of God and have been invested with sacredness and unique value over and above the rest of the created order. We humans are, unlike the other creatures of the earth, created in the image and likeness of God Himself.

Let us make man in our image, in our likeness, and let them rule over the fish of the sea and the birds of the air, over the livestock, over all the earth, and over the creatures that move along the ground. So God created man in his own image, in the image of God created him: male and female he created them (Genesis 1:26-27, NIV).

David, the youthful shepherd, gazed into the starry sky and was overwhelmed at the expanse of the heavens. When he thought about the universe and humanity's place in it, he wondered why God would even care about humans. The answer to that question is rooted in a biblical anthropology.

When I consider your heavens, the work of your fingers, the moon and the stars, which you have set in place, what is man that you are mindful of him, the son of man that you care for him? You made him a little lower than the heavenly beings and crowned him with glory and honor (Psalm 8:3-5).

Why does God care about human beings? Because He sovereignly chose to create us and invest us with sacred worth and unique value. We

are crowned with glory and honor. We are qualitatively different from the other created beings.

This special worth and value is clearly revealed in the covenant God made with Noah when He permitted Noah and his family to eat the meat of animals but declared, "Whoever sheds the blood of man, by man shall his blood be shed" (Genesis 9:6). What is the difference between humans and animals? The distinction is explained in the remainder of the verse -- "for in the image of God has God made man."

The biblical revelation everywhere teaches that human life is sacred and has been invested with special worth by the Creator Himself. This is why it is wrong to kill human beings unjustly. Not only does abortion violate the sanctity of human life, but so do euthanasia and physician-assisted suicide. Only God Himself, or those appointed by God Himself (Romans 13:1-5) have the authority to end human life.

At what point in time does God invest human life with its uniqueness and sanctity? When does human life become sacred? Human life is sacred from the moment of conception. Again, a biblical anthropology correctly informs science. The tools of high-technology medicine make it impossible to deny that the baby in the womb is a *unique* human being from conception. Each individual baby has his or her own genetic code. The heart begins to beat at its own rate in the first month of pregnancy. The baby may have a different blood type than the mother. Everything we know about genetics and embryology points to the fact that the fetus is a developing human being -- not a guppy or a glob of tissue.

Only a biblical view of human life makes sense of what we observe. What is the witness of Scripture about the beginnings of individual human life?

Again, it is David the psalmist who praises God saying,

For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place. When I was woven together in the depths of the earth, your eyes saw my unformed body. All the days ordained for me were written in your book before one of them came to be" (Psalm 139:13-16).

To Jeremiah, the living God declared, "Before I formed you in the womb I knew you, before you were born I set you apart: I appointed you a prophet to the nations" (Jeremiah 1:4-5). The God who has invested human life with special value and sacred worth is the same God who frames and fashions human babies in the womb. Human babies don't *become* human at some variable point in their development. They are *conceived* human. As humans, created in the image of God, they possess the unique sacredness God invests in all human life.

Over 1.6 million human babies, made in God's image, were aborted last year in the U.S. alone! That would be unimaginable if it were not true. While abortion is the focal point of the attack on the sanctity of human life in America, it is but the leading edge of a wedge that will increasingly divide our society. If we can kill the helpless unborn, then we can kill the helpless disabled. If we can kill the helpless disabled, we can kill the suffering ill. If we can kill the suffering ill, we can kill the

unproductive members of society. If developing human life has no value, then perhaps legislators will decide that human life after 70 years of age has no value. What we do to our babies we will do to anyone.

The biblical witness is uniform and clear -- God has invested human life with sacredness and uniqueness from conception onward. The war of world views in our society has many victims, not the least of whom are the unborn babies.

Second, elective abortion violates the most respected tradition in Western medicine. For nearly 2500 years of Hippocratic medicine, especially as it has been enriched by the Christian ethos, elective abortion has been viewed as a violation of the standards of acceptable medical practice. The Oath enjoins a physician never to "give a poison to anyone though asked to do so . . ." nor "to give a pessary to a woman to cause an abortion."² Thus, we believe that offering elective abortion is an egregious revision of compassionate and caring medical practice and represents a quantum shift away from the time-honored legacy of the Hippocratic tradition in medicine. Government funded or mandated abortion in health care reform further aggravates this shift. The physician's most basic duty is summed up in the phrase *primum non nocere*, "first, do no harm." The nearly 30 million abortions performed since the passage of the infamous *Roe v. Wade* Supreme Court decision are a violation of the fundamental norms of medicine.

Third, elective abortion does not regard women's health as a fundamental value. The practice of elective abortion is, in fact, contrary to

²Cited in Nigel M. de S. Cameron, *The New Medicine: Life and Death After Hippocrates* (Wheaton, IL: Crossway Press, 1991), p. 25.

women's health. We are hopeful that the Women's Health Initiative of the National Institutes of Health will shed light on the causes and treatment of a host of illnesses, including breast cancer, colon cancer, heart disease, and osteoporosis. We acknowledge that diseases that disproportionately affect women are less likely to be studied, that women are not well represented in clinical trials, and that women are less likely to be senior investigators conducting the trials.³ We are troubled, however, by the fact that studies on the link between abortion and women's health will not be investigated adequately.

For instance, there is a growing corpus of literature to suggest that elective abortion causes significant psychological trauma to women.⁴ Additionally, research continues to demonstrate the possible correlation between abortion and an increased risk for breast cancer.⁵ Finally, a number of studies have suggested a link between abortion and substance abuse.⁶

³Marcia Angell, "Caring for Women's Health – What is the Problem?" *The New England Journal of Medicine* 329 (4), 1993, pp. 271-272.

⁴Anne C. Speckhard and Vincent M. Rue, "Postabortion Syndrome: An Emerging Public Health Concern," *The Journal of Social Issues* 48 (3), 1992, pp. 95-119. Katherine Dowling, Letter to the Editor, *Journal of the American Medical Association* 269 (17), 1993, p. 2209. Ray Waddle, "Pain of Abortion Can Last a Lifetime for Some," *The Tennessean*, 11/7/93, p. 1-A.

⁵J. C. Willke, *The Deadly After-Effect of Abortion: Breast Cancer* (Cincinnati: Hayes Publishing Co., nd). Joel Brind, "Induced Abortion as an Independent Risk Factor for Breast Cancer," *Association for Interdisciplinary Research in Values and Social Change Newsletter* 5 (3), pp. 1-8.

⁶Reported in *The Post-Abortion Review* 1 (3), pp. 1, 6.

Abortion is the most daunting moral issue facing our nation today. Abortion divides families, religious denominations, professional organizations, political parties, and governmental leaders much the way slavery did during much of the 19th century. Just as there was a dedicated cadre of abolitionists who fought the evil of the commodification of human beings then, Southern Baptists have committed themselves to fight the evil of abortion.

Thus, it should be clearly understood that we will do whatever we are able to vigorously oppose any health reform proposal which includes elective abortion as a component of the plan.

The President and Mrs. Clinton have made it clear that elective abortion will be part of the "comprehensive benefits" offered under the rubric of so-called "pregnancy-related services" in their plan.

Admittedly, the theological and ethical foundations upon which we base our opposition to abortion are not shared by all persons in our culture. There is surprising uniformity on the question of whether or not abortion funding should be part of any potential health care reform. A CBS News/*New York Times* poll published in March 1993 found that 72% of Americans said abortion should not be included in the benefits package of any national health care plan. In their monumental survey of over 100 opinion surveys on public attitudes about abortion, Robert J. Blendon, John M. Benson, and Karen Donelan discovered a clearly defined resistance to the public funding of abortion.⁷ A majority (56%) of Americans say abortion should be either illegal or not paid for by the

⁷Robert J. Blendon, John M. Benson, and Karen Donelan, "The Public and the Controversy Over Abortion," *Journal of the American Medical Association* 270 (23), pp. 2871-2875.

government. More to the point, less than one in three (32%) think coverage of abortion should be included as a part of a basic national health care plan. So, for whatever reasons, the view of Southern Baptists with respect to funding of abortion in health care reform is consistent with that of the overwhelming majority of Americans: no abortion in health care reform!

Impact on Religious Denominations and Churches and Freedom of Conscience

The religious freedom implications of the President's plan are far-reaching. By making abortion a requirement of the comprehensive benefits package, health care reform of the President's variety would compel every denomination and local congregation either to fund abortion or else break the law and suffer its penalties. There would be no "safe harbor." Moreover, every person motivated by religious faith to oppose abortion also would be coerced to support an immoral practice. Every congregation, as an employer, would be required to take money from the offering plate and offer it up to abortionists. The choices would be extremely limited: pay-up and shut-up or face the harsh repercussions of following religious conscience. In a nation which has ranked religious freedom as its first liberty, it is unconscionable that our government would force us to make that choice.

The President has said that there may be "religious exemptions" or a "conscience clause"⁸ so that those who are opposed to public funding of abortion will not have to contribute. Such an exemption is nothing more than a presidential placebo for the pangs of a wounded conscience, intended to try to make religious persons feel better about their participation in the morally nauseating practice of abortion. The Clinton plan would mix private and federal funds for poor women who cannot currently get abortions from Medicaid. Hence, public tax monies would pay for elective abortions. The so-called conscience clause would thus be only smoke and mirrors meant to make persons feel that they were not contributing to something they detest. In fact, however, religious institutions will, if the Health Security Act is passed, either harden their consciences toward the killing of unborn babies or will follow their consciences by engaging in widespread civil disobedience.

The implications for freedom of conscience of individuals are an additional religious liberty concern that we have about the President's plan. That Americans, through taxes or private insurance, would be forced, either directly or indirectly, to pay for the killing of the unborn is particularly reprehensible. Thomas Jefferson wrote in the Virginia Statute on Religious Freedom that "to compel a man to furnish contributions of money for the propagation of opinions which he disbelieves, is sinful and tyrannical. . . ." President Clinton seeks not just the propagation of his opinion about the morality of abortion, he seeks "contributions of money" for the very act of killing unborn children from those who are

⁸John Fairhall, "Abortion Heats Health Debate: Churches Could Opt Out of Coverage," *The Baltimore Sun*, 9/25/93, p. 1-A.

conscientiously opposed to this act. This destroys the essence of true religious freedom.

Even if the problem of the violation of conscience regarding support of abortion is addressed, there remain troubling questions about the impact of the President's plan on local church budgets. The average church in the Southern Baptist Convention has a single employee -- the pastor. An employer mandate system would require churches to pay for a benefit which many cannot currently afford. Such a mandate would inevitably force these churches to reduce or eliminate altogether funding for missions and spiritual ministries, as well as charitable and social ministries. Not only would some churches be forced to scale back their financial support for missions and evangelism (the very heartbeat and fundamental purposes of Southern Baptists), this radical reapportionment of church budgets will place a larger burden on private and especially government welfare programs which provide for the needy. In solving the health care crisis, Congress should not exacerbate the welfare crisis.

We, therefore, can say unequivocally that to the extent abortion on demand remains in the President's plan, the Southern Baptist Convention Christian Life Commission will oppose that legislation.

Encroachments into the Doctor-Patient Relationship

The legacy of Western medical tradition has left us with a deep and abiding commitment to the inviolability of the physician-patient relationship. By taking on the mantle of physician, doctors implicitly, and

often explicitly, enter a covenant relationship with their patients.⁹ Further, embedded in our public consciousness is the notion that physicians do no harm and use their skills for healing and palliation.

Yet, the President's Health Security Act proposes the existence of institutions which would radically violate our accepted norms. Purchasing cooperatives or regional health care alliances encroaches on the physician-patient relationship in a way that is both untenable and unwieldy. This fact has not gone unnoticed by physicians' organizations, including the American Medical Association. Writing in *The New England Journal of Medicine*, physician Marcia Angell alleges that under the Clinton proposal, "Doctors will then be working directly for insurance companies that will attempt to maximize profits by pressuring doctors to do less for their patients, as Relman warned in an earlier editorial. Most of us are already familiar with encroachments by the insurance industry on the practice of medicine. The Clinton plan stands to make this situation worse, not better."¹⁰ Again, the type of reform called for in the President's Health Security Act would fatally erode or completely destroy the covenant between physician and patient which has served us well for 2500 years. Moreover, erosion of a patient's trust in her particular physician and in medicine as a whole will no doubt negatively

⁹William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics* (Philadelphia: Westminster Press, 1983). See also, William F. May, "Code and Covenant or Philanthropy and Contract" in Stephen E. Lammers and Allen Verhey (eds.), *On Moral Medicine: Theological Perspectives in Medical Ethics* (Grand Rapids: William B. Eerdmans Publishing Company, 1987), pp. 83-96.

¹⁰Marcia Angell, "The Beginning of Health Care Reform: The Clinton Plan," *The New England Journal of Medicine* 329 (21), p. 1570.

impact the processes of healing. In this case, as with others, the treatment is far worse than the disease.

Interestingly, abortion proponents themselves do not see the potential problems with such a system. Ms. Kate Michelman is quoted as favoring the Clinton blueprint and maintaining that abortion is "a medical decision to remain between a woman and doctor."¹¹ But, in fact, regional health care alliance personnel would actually make decisions for the physician and patient based upon criteria presumably set by the all-powerful National Health Board. The covenantal relationship between the physician and patient cannot be preserved under reforms which intrude into that relationship. If regional alliances become part of health care reform, intimacy and trust between a physician and her patient will have been sold for the price of increasing bureaucracy.

Rationing Health Care

The sanctity of human life is a doctrine which extends to every human life from conception to natural death. We are, therefore, concerned not only about the ethics of abortion, but ethics at both of the edges of life (and in between). Specifically, we are concerned about the impact of health care reform on the rationing of medically necessary treatments and therapies. In addressing the proposed reforms, Mrs. Clinton has said, "We'll try to reduce the level of defensive medicine in the last six months of life." What exactly does that mean? How will such reductions take place and on what basis?

¹¹"Clintons Defend Abortion Coverage," *The Tennessean*, 9/25/93, p. 13-A.

End-of-life decisions should not be predicated strictly upon economic restraints or government protocols. Neither should health care be rationed or restricted based upon the age, quality of life, or disability of the patient. Systems which discriminate against persons on these bases are abhorrent and unethical.

The United States Holocaust Memorial Museum in Washington, D.C. is a powerful and emotionally moving testimony to the ways a medical system can discriminate against a class of persons. Systems of rationing must not be used to restrict necessary medical treatments on the grounds that the patient is too old or will not regain a "sufficient" quality of life. One needs only recall the label given to victims of the holocaust, *lebensunwertes Leben* (life unworthy of living), to realize how insidious are such notions.

We will vigorously oppose any proposed health care plan that includes rationing based on factors other than medical need.

School-Based Clinics

Finally, we must oppose any health care reform proposal that includes or encourages school-based clinics which counsel for abortion or distribute contraceptives. We find it particularly reprehensible when such clinics do so without parental notification and permission. Pro-abortion counseling and condom distribution without parental notification and consent is a direct assault on the institution of the family and represents a fundamental tear in the basic fabric of any civilized society.

Again, Southern Baptists are on record as opposing school-based clinics. In 1988, the convention, meeting in San Antonio, Texas, passed a resolution saying, in part, "we deplore the operation of School Based Clinics which have as any part of their function the provision of contraceptive counseling, medications, or devices" (see Appendix C). Directly aimed at condom distribution in public

schools, the convention resolved in 1992 to "register our moral outrage at this unprecedented usurpation of parental rights and violation of family integrity and . . . affirm our determination to oppose condom distribution programs in public schools and call upon our educational authorities to refrain from such distribution . . ." and, "that we urge whatever legislative, judicial, or administrative remedies are necessary to terminate condom distribution programs where they already exist, and to implement abstinence-based educational programs in public schools" (see Appendix C).

Southern Baptists are not prudish about sex. Both the Christian Life Commission of the Southern Baptist Convention and the Baptist Sunday School Board produce resources to assist parents to instruct their children about sexuality. Specifically, the Sunday School Board has produced a full line of age-graded sex education materials. These materials have become power tools for parents as they fulfill their role as teachers and moral guides in the home.

Moreover, the Baptist Sunday School Board, the world's largest provider of religious products and services, has initiated a sexual abstinence campaign under the slogan, "True Love Waits." As part of this year-long campaign, half a million teenagers from across the country are expected to sign covenant cards which state: "Believing that true love waits, I make a commitment to God, myself, my family, those I date, my future mate, and my future children to be sexually pure until the day I enter a covenant marriage relationship."

"True Love Waits" has already become highly successful and has garnered a great deal of national media attention.

We call upon the President, Surgeon General Joycelyn Elders, and others in places of authority to institute measures that will encourage our nation's young people to abstain from sexual intercourse until monogamous, heterosexual marriage.

Any health care reform proposal that includes school-based clinics providing abortion counseling for students and contraceptive distribution is a loaded weapon armed with a silver bullet aimed at the hearts of our nation's youth.

Conclusion

Americans stand at the threshold of a momentous decision concerning the kind of society we will be. Will we be a society of life, liberty, and kindness? Or will we be a barbarous and narcissistic society? Will we regard every human being as having intrinsic worth? Or will we make subjective, relativistic quality-of-life judgments about the worth of person's lives?

Whatever our lawmakers choose to do, we must be true to our God, our convictions, and our conscience. We cannot do otherwise. We hope we will be able to stand with our elected officials for revisions and reforms in health care that will evidence our commitment to the intrinsic value of every human life.

APPENDIX A

Health Care Reform: A Moral Preamble*

Christian Life Commission of the Southern Baptist Convention

We believe as citizens of the Kingdom of Jesus Christ, the Great Physician, we are called to participate in the current public dialogue on health care reform. As our Creator is actively concerned and involved in all of life, we, as His disciples, are morally obligated to speak to this value-laden issue. Furthermore, since we are citizens of the United States of America, the addition of our voices is a legitimate expression of the American democratic enterprise and helps to provide a moral and spiritual grounding for the dialogue.

We believe all persons find themselves in need of medical care at various times in their lives. Christians historically have been at the forefront in providing compassionate medical care as a ministry to the people of the world. Southern Baptists have demonstrated their palpable concern for health care on a national level through the establishment of charitable hospitals and clinics. Our Southern Baptist institutions of higher learning have trained countless health care providers. Internationally, we have provided medical personnel and facilities for many of the world's poor. We commit ourselves anew to help meet the health care needs of the world's poor and suffering, wherever they may be.

We believe there is a need for revision in the health care delivery system. We must work harder in both the public and the private sector to help provide affordable care for all those in need.

We believe the key elements in any successful health care reform include reducing unnecessary medical care and costs (with attendant tort reform), liberalizing access to health insurance and providing medical assistance to those

truly in need. This does not necessarily mandate a government-controlled health care system. As Baptists, we are committed to our forebears' insistence on limited government as exhibited in the Constitution of the United States. Government, even with the best of intentions, often breeds bureaucracy, complacency, insensitivity and ineptitude.

We believe the benefits of health care should extend to all of humanity, including the elderly, the chronically ill, the disabled and the unborn. We remain steadfast in our commitment to proclaiming the precious nature and uniqueness of all humanity as created in the image of God. We must oppose, therefore, any attempt to subordinate the life or health of any individual to inferior claims of so-called "reproductive rights," "individual autonomy" or "economic necessity." Public tax monies or proposed mandated employer contributions must not be used directly or indirectly to fund abortion on demand, and end-of-life decisions should not be predicated strictly upon economic constraints or government protocols. The sanctity of every human life is the superior and more humane ethical norm.

We believe the Hippocratic tradition of medicine, especially as it subsequently has been enriched by the Christian ethos, represents the noblest advance of the healing arts. Inherent in this tradition is a deeply personal, covenantal relationship between physician and patient. Compassion and skill supplied by the physician, coupled with the patient's trust and compliance, work together toward healing. Reform efforts must not undermine this time-honored relationship and the enduring values surrounding it. A physician's best efforts to preserve human life must never be impeded by harmful government intrusion. Neither should government in any way discourage or limit access of patients to physicians or counselors of similar life and world views. This is of particular concern in the realm of mental health where the psychological and spiritual are closely interwoven.

We believe the promotion of good health habits is a worthy goal of preventive health care. Proper diet, exercise and regular physical examinations are to be encouraged, and the use of tobacco, alcohol and other harmful drugs is to be discouraged. We encourage moral responsibility by promoting premarital sexual abstinence, marital fidelity and advocacy of the traditional family. At the same time, we recognize a moral obligation to provide compassionate care for all who suffer.

Moral education remains essential in this regard, and we, as members of the body of Christ, recognize our ultimate responsibility to bring the gospel claims of Christ to our world and to demonstrate Christian virtues by being salt and light in a fallen world.

(The Christian Life Commission is the ethics, public policy and religious liberty agency of the Southern Baptist Convention, which is the country's largest Protestant denomination with 15.4 million members in more than 38,000 congregations nationwide.)

* This document issued by the Christian Life Commission was formulated as a consequence of the Southern Baptist Consultation on Health Care Jan. 18, 1994, in Washington, D.C.

Health Care Reform: A Statement of Concerns*

Christian Life Commission of the Southern Baptist Convention

Concern 1 -- Implications for the inalienable rights of human persons, particularly their right to life and liberty, which have been conferred by our Creator and guaranteed in our Constitution. We are especially concerned about the impact of the proposed Clinton plan or any other health care plan on health care at the edges of life. The Clinton plan, at present, includes so-called "pregnancy-related services." Both the President and Mrs. Clinton have made it clear that these services will include abortion services. Along with the majority of Americans, we are opposed to any reform which includes funding for elective abortions.

Without question, the inclusion of abortion on demand in the final version of any health care reform would be the most devastating setback for the pro-life movement since *Roe v. Wade*. In 1973, the pro-life movement was caught by surprise when the Supreme Court decided *Roe v. Wade*. The decision about health care reform will not be by judicial fiat, but will be decided by a democratic political process. And this time the pro-life movement is ready.

Both sides in the abortion struggle agree on the importance of this battle, while, of course, disagreeing on the final outcome. It is unfortunate that the President is apparently so committed to the pro-abortion lobby that he seems willing to jeopardize the most significant social policy legislation of this century for a medical procedure which most Americans agree is elective, except in the rarest of circumstances.

The winner of this debate will have achieved an enormous victory. The pro-abortion movement understands quite well that the inclusion in any "basic benefits package" validates and radically expands their movement. Tens of millions of Americans who are not currently able to pay for abortions (whether because of lack of insurance, insurers' refusal to cover the procedure or the current federal ban on

Medicaid funding of abortion) will have ready access to this procedure under the President's plan. There can be little doubt that, in spite of the President's professed desire that abortion be "safe and legal, but rare," the killing of unborn children will vastly multiply as a result of his national health care plan. Consequently, we are adamantly opposed to any government-funded or government- mandated abortion-on-demand services.

In addition to our concerns about abortion, we are deeply troubled by other aspects of this plan. The sanctity of human life is an issue which goes far beyond the issue of pre-born life. In addressing the proposed health care reform, Mrs. Clinton said, "I haven't told my husband this . . . but we're going to have a living will." She also said, "We'll try to reduce the level of defensive medicine in the last six months of life" (*Washington Post*, September 22, 1993). We will likewise contest any plan which opens the door to or actively promotes euthanasia or physician-assisted suicide as a method of reducing medical expenditures near the end of life. *Primum non nocere* (do no harm), not "kill as few as possible," remains the capstone of the physician's duty to her patient.

Concern 2 – The radical revision of the physician-patient relationship. For more than 2,500 years, medicine in the Hippocratic tradition, especially as it has been informed by the Christian ethos, has been characterized by the inviolability of the covenant relationship between a physician and his or her patient.

The insinuation of health care alliances into the relationship threatens the quality of care and erodes the level of trust between the physician and patient. Reform efforts must not undermine this time-tested relationship and the enduring values surrounding it. A physician's best efforts to preserve human life must never be impeded by harmful government intrusion.

Concern 3 – Religious liberty and freedom of conscience. It is embarrassing that a President who claims the Baptist heritage of religious freedom would consider so violating the consciences of millions of pro-life Americans by forcing them to pay for abortion with their taxes. Thomas Jefferson wrote in the Virginia Statute on Religious Freedom that "to compel a man to furnish contributions of money for the

propagation of opinions which he disbelieves, is sinful and tyrannical. . . . " President Clinton seeks not just the propagation of his opinion about the morality of abortion, he seeks "contributions of money" for the very act of killing unborn children from those who are conscientiously opposed to this act. This destroys the essence of true religious freedom.

Will a person of religious faith be allowed to choose a doctor of a similar world view, within a government-mandated, managed-care system, or will he or she be forced to see a doctor whose world view is clearly in opposition to the patient's deeply held beliefs? This is a serious question in all fields of medicine, but it is absolutely critical in the mental health fields. Will a Christian be forced under this proposed system in a time of mental stress to see a psychologist who is not informed by a Christian world view but rather an opposing or antagonistic world view?

While the President, on MTV, has said that most health alliance plans will cover abortions, there will be what he called "religious exemptions" or a "conscience clause" so that some health plans do not have to include abortion services (*Baltimore Sun*, September 25, 1993).

President Clinton has acknowledged to reporters that tax funds and employer-mandated contributions, presumably even from those persons morally opposed to abortion, would be used "indirectly" to pay for abortions. The conscience clause then is merely smoke and mirrors.

Southern Baptists still maintain, through their state conventions, some oversight of denominationally operated hospitals. Most of those hospitals do not offer elective abortion services. We are concerned about the Clinton proposal's impact on the religious liberty of those facilities that refuse to perform abortions.

Concern 4 – Allocation of finite medical resources. We believe that the benefits of health care should extend to all humanity, including the elderly, the chronically ill and the unborn.

Health care rationing based on factors other than medical need and patient willingness are ethically suspect. In particular, age-based systems of rationing are unjust and discriminatory. Systems which discriminate on the basis of quality of life judgments or mental or physical disability are especially abhorrent. We will oppose any form of restricted access based on age, quality of life or disability.

Concern 5 – Interference with families. Again, as the Clinton plan presently exists, it includes so-called "family planning services." We will resist any plan which will fund abortion counseling, contraceptive distribution to minors, medical care without parental consent and school-based clinics which facilitate these activities.

Concern 6 – Impact on Southern Baptist entities and agencies, including local churches. Most Southern Baptist pastors, agency employees and missionaries are covered by insurance plans which are under the aegis of the Annuity Board of the Southern Baptist Convention. The consultation made clear that every Southern Baptist, every Southern Baptist church and every Southern Baptist organization will be impacted significantly by any of the health care reform proposals currently under consideration. We are concerned that Southern Baptists, along with most Americans, may be worse off under the Clinton blueprint.

* A statement of concerns is an evaluative grid that is formulated as a consequence of a consultation on health care reform hosted by the Southern Baptist Convention Christian Life Convention Jan. 18, 1994. The purpose of the consultation was to analyze the ethical, legal and social implications of health care reform.

APPENDIX B

ON THE FREEDOM OF CHOICE ACT, HYDE AMENDMENT
AND OTHER ABORTION POLICIES

WHEREAS, The Bible teaches that God holds human life to be sacred because He created human beings in His own image (Gen. 1:27, Gen. 9:6); and

WHEREAS, Southern Baptists have historically affirmed biblical teaching regarding the sanctity of human life by adopting numerous pro-life resolutions at national, state and associational meetings; and

WHEREAS, Approximately 1.6 million unborn babies are now being killed each year in America, nearly 30 million in the past 20 years, as a result of the 1973 decision of the Supreme Court in *Roe v. Wade*; and

WHEREAS, Last year in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court reaffirmed the central holding of *Roe* and further entrenched abortion "rights" in the Constitution; and

WHEREAS, Although *Casey* reaffirmed abortion rights, states still retain a limited ability to regulate and restrict abortion; and

WHEREAS, The Freedom of Choice Act which is now poised for passage in the United States Congress, and would, if adopted, result in a national abortion-on-demand law prohibiting states from regulating and restricting abortions in any meaningful way, even during the last three months of pregnancy; and

WHEREAS, President Clinton and pro-abortion legislators in Congress are also attempting to repeal the Hyde Amendment and other pro-life policies which prohibit taxpayer funding of abortion; and

WHEREAS, Health care reform being considered by Congress and the Clinton Administration is likely to require taxpayers and private employers to pay for abortion in spite of their moral objections to this policy; and

WHEREAS, Congress is currently considering legislation which would deny pro-lifers their First Amendment freedom of speech rights during responsible non-violent protests outside abortion clinics; and

WHEREAS, President Clinton has instructed the Food and Drug Administration to make certain abortion pills available in the United States; and

WHEREAS, President Clinton has repealed the ban on federally-funded research using electively aborted fetal tissue in scientific experiments.

Therefore, Be it RESOLVED, That we, the messengers to the Southern Baptist Convention, meeting in Houston, Texas, June 15-17, 1993, affirm the biblical teaching that God is the author of life and that human life begins at conception (Psa. 51:5; 139:14-16; Jer. 1:5); and

Be it further RESOLVED, That we affirm the biblical prohibition on the taking of unborn human life except to save the life of the mother; and

Be it further RESOLVED, That we oppose all efforts by the United State Congress to pass the radical abortion on demand bill, the Freedom of Choice Act; and

Be it further RESOLVED, That we call upon Congress to maintain the Hyde Amendment and other pro-life policies which prohibit the use of federal funds to encourage, promote, or perform abortions except to save the life of the mother, thereby protecting the unborn and the consciences of millions of pro-life taxpayers; and

Be it further RESOLVED, That we oppose the inclusion of abortion in any health care plan which may be proposed by the President and adopted by Congress and urge policy makers to protect the consciences of millions of pro-life taxpayers and employers by not forcing them to pay for such a repugnant act; and

Be it further RESOLVED, That we oppose the passage of any legislation which would have the effect of denying First Amendment freedom of speech rights, especially as a means of responsible, non-violent protest at abortion clinics; and

Be it further RESOLVED, That we oppose the testing, approval, distribution, marketing and usage in the United States of any abortion pills and urge U.S. corporations which are considering such business ventures to refuse to do so; and

Be it finally RESOLVED, That we remain morally opposed the use of electively aborted fetal tissue in all experiments conducted by the federal government and urge President Clinton to reconsider his decision to advance such reprehensible research.

ON SANCTITY OF HUMAN LIFE

WHEREAS, The Bible teaches that God holds human life to be sacred and created human beings in His own image; and

WHEREAS, Southern Baptists have historically affirmed biblical teaching regarding the sanctity of human life by adopting numerous pro-life resolutions at the national, state, and local levels; and

WHEREAS, Approximately 1.6 million unborn babies are killed each year in America as a result of the 1973 decision of the Supreme Court in *Roe v. Wade*; and

WHEREAS, In 1989 the Supreme Court began the dismantlement of the Roe decision by upholding a Missouri pro-life statute in *Webster v. Reproductive Health Services*; and

WHEREAS, As a result of the Webster decision, states now have more flexibility to regulate and restrict the practice of abortion; and

WHEREAS, The Supreme Court is likely to erode or overturn the *Roe* decision in the near future; and

WHEREAS, Legislation has been introduced in the United States Congress which would codify and expand the Roe abortion rights and thereby restrict the rights of states to regulate abortions within their borders; and

WHEREAS, Pro-abortion legislators in Congress are also attempting to repeal restrictions on federal abortion funding; and

WHEREAS, New drugs and technologies, including RU-486, which will make the practice of abortion easier, are being researched and used in other nations and abortion advocates are attempting to bring these technologies to America; and

WHEREAS, Some scientists in America are experimenting with the tissues of babies from induced abortions in order to find cures to certain diseases and are working to repeal the ban on federal government research on fetal tissue transplantation; Now, therefore,

BE IT RESOLVED, That we the messengers to the Southern Baptist Convention, meeting in Atlanta, Georgia, June 4-6, 1991, affirm the biblical prohibition against the taking of unborn human life except to save the life of the mother; and

BE IT FURTHER RESOLVED, That we call on all Southern Baptists to work for the adoption of pro-life legislation in their respective states which would expand protection for unborn babies; and

BE IT FURTHER RESOLVED, That we call on all Southern Baptists to work with equal fervor to compassionately encourage and assist girls and women with unplanned or unwanted pregnancies to carry their children to term and to prepare for the best life possible for their children; and

BE IT FURTHER RESOLVED, That we opposed all efforts by the United States Congress to limit the rights of states to restrict abortion-on-demand and call upon

Congress to maintain current pro-life policies which prohibit the use of federal funds to encourage, promote, or perform abortions except the save the life of the mother; and

BE IT FURTHER RESOLVED, That we oppose the testing, approval, distribution, and marketing in America of new drugs and technologies which will make the practice of abortion more convenient and more widespread; and

BE IT FURTHER RESOLVED, That we support the current federal government ban on funding any transplantation of tissue from induced abortions for purposes of experimentation and research and call on the federal government to maintain the ban despite pressure from the scientific community and pro-abortion organizations.

ON ENCOURAGING LAWS REGULATING ABORTION

WHEREAS, Southern Baptists have historically upheld the sanctity and worth of all human life, both born and pre-born, as being created in the image of God; and

WHEREAS, the messengers to the annual meetings of the Southern Baptist Convention during the past decade have repeatedly reaffirmed their opposition to legalized abortion, except in cases where the mother's life is immediately threatened; and

WHEREAS, the Supreme Court of the United States in the 1973 Roe V. Wade decision, and its progeny, denied the right of the fifty state legislatures and the Congress to protect the preborn child by law; and

WHEREAS, the Court may now be willing to permit the states and the Congress once again to enact legislation regulating and restricting abortion.

Therefore, be it RESOLVED, That we, the messengers of the Southern Baptist Convention, meeting in Las Vegas, June 13-15, 1989, to strongly urge the fifty state legislatures and the Congress to enact legislation to restrict the practice of induced abortion; and

Be if further RESOLVED, That we urge the Christian Life Commission and the various state Baptist conventions, and their Christian Life Committees, affiliated with the Southern Baptist Convention actively to promote the passage of such legislation; and

Be it finally RESOLVED, That we do reaffirm our opposition to legalized abortion and our support of appropriate federal and state legislation and/or constitutional amendment which will prohibit abortion except to prevent the imminent death of the mother.

APPENDIX C

ON SCHOOL BASED CLINICS

WHEREAS, A continuing permissive attitude in contemporary society toward extramarital sexual activity has precipitated an epidemic of teenage pregnancy; and

WHEREAS, Many public school systems across America believe that the most effective way to combat this problem is to make birth control information and contraceptives widely available to public school students; and

WHEREAS, This mindset has led to the provision of amoral counsel, of contraceptive medications, and devices within the framework of public schools; and

WHEREAS, The newest assault on parental authority and responsibility with respect to their adolescent children is the concept of School Based Clinics, which are being introduced into public schools across the country with the ostensible reason being to provide general medical services to public school students; and

WHEREAS, Many proponents of School Based Clinics claim that contraceptive services and treatment of sexually-related medical conditions are only a small portion of the total services to be delivered, it is obvious because of the philosophical base of their chief proponents that general medical services are only a camouflage for their primary motivation which is to provide contraceptives to public school students; and

WHEREAS, Provision of contraceptive services in School Based Clinics is virtually always done under the cover of patient confidentiality, resulting in the provision of contraceptive services, medications, and devices without parental knowledge or permission, undermining God-ordained parental authority and responsibility; and

WHEREAS, This causes the public school, which represents to students the authority of the government and of the community at large, to condone immoral sexual behavior; and

WHEREAS, That for public schools to condone and lend assistance to immoral sexual behavior is an abdication of moral responsibility and a breach of the trust which parents expect from those to whom they entrust the education of their children.

Therefore be it RESOLVED, That we, the messengers of the Southern Baptist Convention meeting in San Antonio, Texas, June 14-16, 1988, abhor the tendency to bypass parental consent involving birth control and abortion; and

Be it further RESOLVED, That we deplore the operation of School Based Clinics which have as any part of their function the provision of contraceptive counseling, medications, or devices; and

Be it further RESOLVED, That we do not believe that any fair interpretation of the doctrine of separation of church and state requires the public schools of our nation to adopt and maintain an amoral value-free approach to teenage promiscuity, and we call for public schools as they deal with the sensitive areas of sexual behavior to uphold the standard of sexual abstinence outside marriage; and

Be it further RESOLVED, That we support those public school educators in their efforts to promote traditional moral values that teach abstinence; and

Be it finally RESOLVED, That if "Just Say No" is the standard for drug education, we affirm that it is equally applicable to sex education.

ON CONDOM DISTRIBUTION IN THE PUBLIC SCHOOLS

WHEREAS, an increasing number of public school districts are distributing condoms to students through the public schools; and

WHEREAS, These condoms are often distributed without the knowledge and consent of parents; and

WHEREAS, The dangerous myth of "safe sex" continues to claim victims, including young children in public schools; and

WHEREAS, The forced availability of birth control devices to minors violates the rights of parents and guardians, endangers the health and lives of children, and is a violation of the rights of the family.

Therefore, Be it RESOLVED, That we, the messengers to the 135th session of the Southern Baptist Convention, meeting in Indianapolis, Indiana, June 9-11, 1992, register our moral outrage at this unprecedented usurpation of parental rights and violation of family integrity; and

Be it further RESOLVED, That we affirm our determination to oppose condom distribution programs in public schools and call upon educational authorities to refrain from such distribution; and

Be it finally RESOLVED, That we urge whatever legislative, judicial, or administrative remedies are necessary to terminate condom distribution programs where they already exist, and to implement abstinence-based educational programs in public schools.

Mr. WAXMAN. You have all given us very clear and articulate statements of your positions and obviously this panel does not speak with one voice on this issue. I don't think there are any questions I could ask any of you that would bring out any clearer what views you want to have on the record as we consider this legislation. All I will do is thank you very much for being with us.

Mr. Greenwood, do you have any questions?

Mr. GREENWOOD. I have a couple of questions. First, Ms. Alvaré and Mr. Mitchell, do you support in a basic benefits package contraceptive services?

Ms. ALVARÉ. With regard to contraception, you know the moral position of the Bishops between artificial contraception and natural contraception. It is a position that we distinguish from the abortion position. It is a morality position, not a human rights position, about whether or not certain human lives can be destroyed.

First of all, we want to urge upon all of the Members of Congress considering this that they should be under no illusions that if they include contraception in this, expand it, make it even more easily available that somehow that will result in fewer teen pregnancies and fewer abortions. I have a great variety of statistics I would be happy to provide you showing that the last 20 years expansion has not resulted in lower abortion or teen pregnancy rates, but in fact, as you know, they have been increasing.

Second, we cannot actually say we are going to support forcing our employers to pay for contraception against our religious and moral conscience and so forth. We need conscience clause protection because you know that you would be speaking directly to a matter of religious concern to us if contraception was included.

Mr. GREENWOOD. Maybe Mr. Mitchell could respond to my first question and to my second question. We now have abortion and contraception, at least from Ms. Alvaré's testimony, as items where individuals ought to be able to conscientiously object and not provide any funds for a national pool or regional pool.

Is there any philosophical reason why others could not extend that to the treatment of AIDS, to the treatment of drug and alcohol abuse, or to the treatment of sexually transmitted diseases, all of which are self-induced problems in the minds of many?

Where are we supposed to draw the line when allowing individuals to opt out from any contribution toward the cure of certain ills?

Ms. ALVARÉ. Were you following up with me on that question?

Mr. GREENWOOD. Either or both.

Ms. ALVARÉ. With regard to the statement of curing ills, the line you draw is the line that I would agree with. Abortion does not cure an ill. Abortion terminates a life. To try and say that you start here and the slippery slope would lead you to objection to a huge variety of things would not be precise intellectually or otherwise.

Again the Supreme Court, doctors, everyone pretty much acknowledges that abortion is *sui juris*. It is intended to terminate a life which is human and developing. To have an objection to that in particular, I don't think can be compared to any other kind of objection.

I know this morning there were questions raised about how do we feel about treating persons who used alcohol or drugs. Again,

we are still talking about a treatment for curing an ill. When we talk about abortion, we are talking about an operation that actually destroys a life.

Mr. GREENWOOD. I thought the slope got a little more slippery when you talked about contraception because that is not in the same category.

Ms. ALVARÉ. With regard to contraception, you are speaking there of something that deals specifically with a religious precept held for thousands of years by a particular church. You are not talking about destruction of human life, that is granted. On the other hand, you are talking—

Mr. GREENWOOD. Should Christian Scientists be excluded in the same way from paying for things that violate their religious beliefs?

Ms. ALVARÉ. This morning you referred the possibility of opt out with regard to abortion. That still leaves our Federal Government in the position of enforcing abortion as if it is morally indifferent between that and prenatal care.

With regard to questions that are not about the destruction of human life but rather involve the religious liberty tradition of our country for hundreds of years, that is a slightly different question. We could get into particular things that are of interest to each religion.

But yes, when something violates particular precepts of religion, I think conscience clauses are appropriate for Congress to consider.

Mr. GREENWOOD. Mr. Michelman, if you will indulge me, I would just like to ask if anyone from the other side of the debate would like to offer any comments in this regard.

Ms. MICHELMAN. The issue of pregnancy and an abortion being different from a disease, the fact is that an unintended, unwanted pregnancy creates an enormous health risk, not only for the women's health—and we have to remember that pregnancy is a high-risk condition for many, many women. But it not only can, it doesn't always, but it not only can threaten a woman's physical health, but it can threaten the rest of her health, her family's health, and well-being.

Bringing a child into this world is one of the most important health decisions and any other kind of label you can put on it, one, if not the most important decision we can make. So to limit the discussion about childbearing and reproductive decisionmaking to whether it is treating a disease or not, is a very narrow formulation and a very rigid and punitive view of reproductive decision-making.

Again, as I said in my testimony, it is important for this Nation to take reproduction more seriously. It is important for this Nation to turn its attention to making abortion less necessary. Ms. Alvaré just said that they oppose contraception which is one of the most vital ways to prevent the need for abortion. We need to make abortion less necessary.

I would also like to correct on the record something Ms. Alvaré said in her statement that I said abortion was a bad thing. The reporter quoted me absolutely incorrectly. What I said was that the fact that we have so many abortions in this country represents a

failure of policy, a failure of value, that prevention should be stressed, not that abortion is a bad thing.

Abortion is a moral choice that women make when faced with an unintended pregnancy, but there is a failure in our Nation when we have 3 million unintended pregnancies, 1 million teenage pregnancies, 600,000 low birth weight babies born each year, and 35,000 infants dying every year. There is a failure of reproductive health. What I am saying about the plan is that it needs to wholly address and comprehensively address these issue by stressing prevention through contraception, through school-based health clinics, through education and access to health care by stressing prenatal care and universal access.

There are women who have abortions in this Nation solely because they cannot figure out how to get health care for themselves during the pregnancy and for their child after the child is born. That is the truth. I think that health care reform can markedly affect the number of unintended pregnancies and abortions.

But when the final question comes and the pregnancy is a fact of life, only the woman can make a judgment about her own health and her family's health. I would say "health" in the broad sense of the word. I think we need to get beyond this divisiveness over abortion, make abortion less necessary as our effort, but ensure that choice is available to women.

Mr. WAXMAN. Thank you very much, Mr. Greenwood.

Mr. Towns, do you have any questions?

Mr. TOWNS. I have no questions at this time, Mr. Chairman.

Mr. WAXMAN. I want to thank all of you for your participation. It was very helpful.

[The following letters were received:]



Secretariat for Pro-Life Activities

3211 Fourth Street, NE Washington, DC 20017-1194 (202) 541-3070 FAX (202) 541-3054 TELEX 7400424

February 4, 1994

The Honorable Henry Waxman
Chairman, Subcommittee on Health and Environment
House Energy and Commerce Committee
2125 Rayburn House Office Building
Independence and South Capitol Street, S.W.
Washington, D.C. 20515

Dear Congressman Waxman:

Thank you for the opportunity to testify before the Subcommittee on Health and Environment on January 26. During my testimony, I used a quotation attributed to Kate Michelman of the National Abortion and Reproductive Rights Action League in a Knight-Ridder story: "We think abortion is a bad thing." Ms. Michelman responded in the question and answer period that she had been misquoted.

Since that time, the reporter who quoted Ms. Michelman in that story has verified that Ms. Michelman did use the exact language I repeated in my testimony. Because the accuracy of my written and oral testimony regarding this quotation was disputed, I would appreciate your entering into the record the attached letter from the Knight-Ridder reporter who wrote the story from which the quotation was taken.

Thank you.

Very truly yours,

Helen M. Alvaré
Director of Planning
and Information

HMA:mng

Enclosure

HENRY J. HYDE
6TH DISTRICT, ILLINOIS

COMMITTEES
JUDICIARY
FOREIGN AFFAIRS

CHAIRMAN
REPUBLICAN POLICY COMMITTEE

2110 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-1306
(202) 225-4561

Congress of the United States
House of Representatives
Washington, DC 20515-1306

February 10, 1994

The Honorable Henry Waxman
Chairman
Subcommittee on Health and The Environment
Committee on Energy and Commerce
2415 Rayburn HOB
Washington, D.C. 20515-6118

Karan

Dear Henry:

Thank you for the opportunity to testify on behalf of the House Pro-Life Caucus before the Subcommittee on Health and the Environment on January 26, 1994. I certainly appreciated the help in finding a time that was accommodating to the schedules of Representatives Barbara Vucanovich, Chris Smith and myself.

During testimony later that day, Helen Alvare of the National Conference of Catholic Bishops used a quotation attributed to Kate Michelman of the National Abortion and Reproductive Rights Action League. The following quote appeared in a Knight-Ridder story: "We think abortion is a bad thing." In the question and answer period of her testimony, Ms. Michelman stated that she had been misquoted.

The reported who quoted Ms. Michelman has since verified the accuracy of the original quote. In fact, the quote in question was recorded during the interview with Ms. Michelman. Ms. Alvare has submitted a letter dated February 4, 1994, requesting that the enclosed letter from Jodi Enda (the reporter who interviewed Ms. Michelman) be inserted into the hearing record. I agree with Ms. Alvare that the accuracy of her testimony was under question, and the enclosed letter (and Washington Post article) confirms that Ms. Alvare's remarks were indeed accurate.

Thank you for your assistance in this matter.

Cordially,

Henry Hyde
Henry Hyde

The Philadelphia Inquirer

400 North Broad Street
P.O. Box 8283
Philadelphia, PA 19101

Douglas Johnson
Legislative Director
National Right to Life Committee
Suite 500
419 7th St., N.W.
Washington, D.C. 20004

Jan. 31, 1994

Dear Mr. Johnson:

This is in response to your letter, dated Jan. 29, 1994, asking me whether I could affirm a quote attributed to Kate Michelman in a story that ran in the Philadelphia Inquirer on Dec. 11, 1993.

The answer is a firm yes. I can confirm that Michelman said the following, in an interview that I tape recorded in her office: "We think abortion is a bad thing. No woman wants to have an abortion." She went on to say: "We've just concentrated on abortion -- and the nation has been forced to concentrate on abortion -- because the other side has made abortion the only reproductive issue people talk about. We want to change that." I quoted that as well.

After the story was published, Michelman wrote a letter to the Inquirer asserting that she never said "abortion is a bad thing." When an editor reminded Michelman's press secretary, Karen Schneider, that the interview was taped and that Schneider was present during the conversation, and added that I transcribed the tape to ensure the accuracy of all quotes before writing the article, Schneider asked that Michelman's letter be withdrawn.

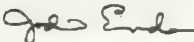
Instead, Michelman submitted a second letter, which was published on the Inquirer's editorial page Dec. 25, 1993, in which she said she wanted to "clarify" her remarks, but did not deny the accuracy of any quotes. In part, her letter said: "It is not abortion itself that is a bad thing. Rather, our nation's high rate of abortion represents a failure -- of inadequate sexuality education, of poor

contraceptive care, of a health-care system that does too little to help women avoid unintended pregnancy." She went on to say that the National Abortion Rights Action League, which has since changed its name, was working to reduce the number of unintended pregnancies, to promote better sexuality education, contraceptive options and family planning. "We would like to see fewer women have to face the difficult decision about abortion -- but women's choices must be valued and respected," Michelman wrote in the published letter.

The Inquirer and I stand by the story as published.

Thank you for bringing the matter to my attention.

Sincerely,



Jodi Enda

Mr. WAXMAN. For our last panel I want to call Dr. Katherine Alley who is the National Breast Cancer spokesperson for the American Cancer Society. Fran Visco is the president of the National Breast Cancer Coalition, and Dr. John Curd is clinical director for immunology of Genentech.

We are pleased to welcome you to our hearing today. Your prepared statements will be entered in the record in full. We would ask, however, that you have limit the oral presentation to no more than 5 minutes.

STATEMENTS OF KATHERINE ALLEY, ON BEHALF OF AMERICAN CANCER SOCIETY; FRAN VISCO, PRESIDENT, NATIONAL BREAST CANCER COALITION; AND JOHN CURD, CLINICAL DIRECTOR FOR IMMUNOLOGY, GENENTECH INC.

Ms. ALLEY. Good afternoon, Mr. Chairman and members of the committee. I am Katherine Alley. I am representing the American Cancer Society and I am accompanied by Dr. Robert Smith, our senior director of detection programs.

I am grateful for the privilege to be here this afternoon. The American Cancer Society pledges its support to work with President Clinton and Members of Congress to enact health care reforms which meet the cancer prevention and control needs of all Americans. My written statement provides details and specific recommendations relating to women's health.

We support the principles of President Clinton's health reform plan. However, the Clinton plan is at variance with the breast cancer screening guidelines of the American Cancer Society and many other medical, health and consumer groups.

The public debate over the value of screening mammography has caused concern and confusion among some women and health professionals and worse, has the potential of deterring women of all ages from getting a mammogram. Those who oppose routine mammography for women age 40 to 49 claim, in the words of the NCI statement, that randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50. This statement is incomplete and therefore inaccurate.

It would be more accurate to say that the current studies are inadequate to answer the question does mammography save lives in women under the age of 50. The reason these studies are inadequate is that they were designed to look at the benefits of mammography over a wider age range of women. Because of this, it is impossible to apply the results to a more limited age range, as the 40 to 50 year-old group.

In the language of statistics, they are under powered. However, the majority of these studies suggests a benefit. It means that widespread participation in mammography screening among women in this age group could ultimately result in 2,000 to 3,000 fewer breast cancer deaths each year and perhaps even more as well as offering women options in treatment and improved quality of life.

Those who oppose screening will say that meta analysis solves the problem of the inadequacy of individual studies. However, these studies are almost impossible to combine due to variations in

design technology, screening intervals, and a whole host of other factors.

It is the assertion of the American Cancer Society that it is not good science to claim that mammography is not effective in this age group when the research studies to date have been inadequate to answer the question.

It is also not good science to say that the needs of women in this age group will be met if revisions are made to screen those who fall into certain risk categories. Allow me to point out how dangerous this approach would be since 80 percent of women with breast cancers have no risk factors.

We know this will leave the majority of women diagnosed in this age group unprotected. It is also not good public health. Breast cancer represents a significant health problem to women of all ages and particularly those 40 to 49 years old. It is their number one health concern with good reason, it is their number one cause of death.

The American Cancer Society cannot set women's needs aside because of a failure to study this question in such a manner that the existing evidence was as definitive as we have for women age 50 and older.

We believe the coverage should be available and that all women should talk with their providers to be fully apprised of the evidence. In that context, they can reach an informed decision.

We do support creative methods to pay for mammography including copayments for women financially able to contribute to their own health care.

Finally, we believe the administration should aggressively support studies which examine the efficacy of mammography in the 40 to 49 year old age group and the interval of screening women over 50. Until we have the definitive answers, however, women's access to mammography should not be limited.

The economics of health care are important to the health reform debate and policy makers are struggling with the desire to match the availability of health care with those populations who need it most. We have believe that all lives that can be saved with this lifesaving tool of mammography should be saved.

In closing, Mr. Chairman, let me give this some real meaning. I am one breast surgeon in one city in this country. I have had 45 patients in the last 2 years who were cured of their breast cancer because it was found during a pre-invasive stage by routine mammography.

Yesterday I operated on a Congressman's chief of staff whose cancer was found on a screening mammogram. If the President's guidelines had been in place, she would not have been eligible for screening and her diagnosis would have been delayed to a point past cure.

I urge you to support the use of routine mammography in this group at a time when early detection is a patient's best hope for being cured.

Mr. WAXMAN. Thank you very much, Dr. Alley.

[The prepared statement of Dr. Alley follows:]

STATEMENT OF KATHERINE ALLEY

Mr. Chairman and members of the Committee, I am grateful for the privilege to be here this morning. The American Cancer Society commends you for conducting this hearing on women's health and health reform.

The American Cancer Society is the nationwide, community-based voluntary health organization dedicated to eliminating cancer by preventing cancer, saving lives from cancer, and reducing suffering from cancer through research, education and service. The Society applauds the President and First Lady for making health reform a top priority and for bringing this issue to the American people. We recognize the leadership over the years of Members of this Committee and other Members of Congress, and renew our commitment to work with you to enact comprehensive health reform that will best meet the needs of cancer patients and those who are at risk of cancer, and to address the health care crisis in this country.

I do not use that phrase lightly. The quality of our research program and available health care services, including state of the art technology and therapies to prevent and control disease, is arguably the best in the world. The majority of Americans who have health insurance coverage are pleased with the quality of care they receive. While these statements may be true, they are at odds with the fact that millions of uninsured, underinsured, and chronically ill Americans and their families do not receive even the most basic health care services. It ignores the fact that millions of Americans receive their care in hospital emergency rooms, at great cost to all in society, and more importantly at a time when their health problems may have progressed beyond the point of effective medical intervention. This system in crisis ignores the millions of Americans who are added to the ranks of the uninsured every year as rising costs of health care force businesses to abandon coverage for employees and their dependents. A band-aid approach to health reform will not address the never-ending cycle of rising costs and declining access, or the cost-shifting that occurs among governments, employers and employees, insurance companies, and tax payers.

Moreover, the current health care system dismisses the tens of millions of Americans suffering with disease, disability or other health disorders - including more than 8 million Americans living with cancer, and 1 million Americans who will be diagnosed with cancer this year alone. These individuals and their families are victims, not of cancer, but of a system that leaves them vulnerable at a time when they are fighting for their lives. Our current system locks cancer patients or their spouses or parents into jobs or other life situations for fear of losing whatever health care coverage they may receive for themselves and their family members. More often than not, cancer patients are forced into poverty in order to pay for continuing medical treatment and rehabilitation, as well as routine care because they lose their insurance coverage or it becomes unaffordable once they have a diagnosis of cancer or other health problem.

The American Cancer Society has adopted a Statement of Principles for Health Care System Reform which outlines these and other critical cancer prevention and control needs for all Americans. Today, we will speak specifically to the aspects of health reform that deal

with women's health. Lung cancer is the number one cancer killer in women - 59,000 will die in 1994 alone - and tragically, smoking-related deaths are entirely preventable. We applaud one of the most significant preventive health components of the President's health plan - a \$.75 increase in the federal cigarette tax, and comparable increases for other tobacco products. The American Cancer Society, the American Heart Association, and the American Lung Association - united as the Coalition on Smoking OR Health - have called for a minimum tax increase of \$2.00 per pack of cigarettes, a proposal that is supported by 66% of the American public. A major tobacco tax increase would simultaneously help pay for health care reform, offset the enormous burden tobacco imposes on our economy and, most importantly, discourage millions of young people from beginning to smoke in the first place, including record numbers of young women who are lured into the habit every day. Importantly, an increase of \$2.00 per pack will save an estimated 1 million more lives over time than the President's proposed tax of \$.75, and will bring in billions of dollars in additional revenues to support health care access.

One of the most important issues for those living with cancer is the adoption of provisions that will guarantee universal coverage for all women and men to timely, high-quality health care, including preventive health and cancer care. The American Cancer Society believes in individual responsibility. Everyone should contribute to the costs of their health care, and should be empowered with information about healthy lifestyle choices and ensured access to routine screening exams to save lives and reduce suffering. However, universal access can be compromised by the high cost of care and/or insurance premiums, and health reform should spread costs among all sectors so that everyone pays some share of health care and so that coverage for individuals is affordable and provides true "universal access".

In terms of benefits, the American Cancer Society has identified a wide range of services that should be provided for women who have cancer or who are at risk for cancer, including routine physical examinations which include appropriate preventive health counseling such as nutrition counseling and health education which examines the dangers of tobacco use, promotes breast and cervical cancer screening at intervals recommended by the American Cancer Society, and appropriate self-examinations for skin, breast and other cancers.

Upon diagnosis with cancer or other illness, all women should be provided with information about, and timely access to, high quality, state of the art diagnostic, treatment, and rehabilitative services. The American Cancer Society believes that any health reform plan should emphasize choice - that of the patient and the health care team, and ensure that the primary care physician act as facilitator, rather than gatekeeper, to obtaining care. We are also concerned that the definition of a primary health care provider be interpreted broadly to reflect the needs of cancer patients and others with specific health conditions. The American Cancer Society has called for increased participation by women in clinical studies and research trials of new drugs or therapies, preventive and screening/diagnostic care. Coverage should be provided for all women who participate in approved clinical trials, with

full coverage for care given in conjunction with that trial. Clinical trials should be expanded for minority and underserved women. In addition, we support coverage for off-label (unlabeled indication) of approved cancer therapies or other modalities for all Americans, according to the standard available for Medicare beneficiaries.

Finally, it is critical that we significantly step up medical research to determine the cause and cure for all cancers, with special emphasis on priority cancers such as breast and ovarian, where we have little information about prevention or cure. Equally important is ensuring that our health care system facilitates the translation of research into clinical practice. We strongly recommend that Congress maintain and expand the public health service infrastructure that is a critical component, in conjunction with federal community health centers, state and local health departments, and community organizations like the American Cancer Society, in targeting and reaching underserved populations.

Mr. Chairman, in your invitation to the American Cancer Society, you asked us to discuss the issue of mammography screening guidelines, and to provide our guidance on how this will impact coverage under health reform. While we strongly support, in principle, the Clinton plan as it addresses many of the cancer control principles identified above, the President's plan is at variance with the breast cancer screening guidelines of the American Cancer Society and 21 other national medical organizations, health and consumer groups. The plan provides a routine screening mammogram for women aged 50 and over every two years, with no cost-sharing. It does not, however, provide for routine mammography for asymptomatic women between the ages of 40 and 49 years as is recommended by the American Cancer Society. A recent document provided by the Department of Health and Human Services clarifies the coverage under the Clinton plan, to say that woman of any age who are defined to be at risk of breast cancer, may receive mammograms at a schedule "appropriate to their risk status", with no cost-sharing. The document further specifies that women of any age can receive mammograms at any time when they are "medically necessary or appropriate" as specified by the woman's health plan, with appropriate cost-sharing by the woman. The White House has explained that these benefits, and their exclusions, are based on the best and most recent scientific evidence. Let me express our concerns about this element of the plan, and it's alleged scientific basis.

First, the science. We have solid epidemiologic and clinical evidence that routine screening for breast cancer with mammography and clinical breast examination is effective in reducing breast cancer mortality. This conclusion is based on the evaluation of studies in which deaths from breast cancer were significantly lower in the groups invited to be screened with mammography compared with control groups that did not receive an invitation to screening. In effect, we have a proven intervention that can save women's lives at time when we are unable to prevent this disease.

However, because each of these studies was carefully designed to test the efficacy of mammography in mortality reduction from breast cancer in a 25-30 year age-range of women, there are limitations to what they can tell us about the efficacy in 5-10 year age

ranges of women, such as those between the ages of 40 and 49. In the language of statistics, they are underpowered, which means that there are too few women in the study for us to rule out that the findings, which in the majority of these studies suggest a benefit, did not occur by chance alone. Even the study recently conducted in Canada, which was specifically designed to address the 40-49 issue, has been judged to be statistically underpowered in addition to numerous other shortcomings that have compromised its potential to offer guidance on this question. This situation is analogous to the summary of a political poll, when listeners are told that the estimate of voter's preferences are accurate within 3 percentage points. The accuracy of the estimates of the benefit of mammography in women aged 40-49 in these studies is often in the range of 20-30 percentage points, meaning that it is entirely possible that the benefits are far greater than is suggested in the majority of existing studies. Potentially, between two and three thousand women's lives, or even more, could be saved each year through the availability of mammography for this age group. Indeed, we believe that the widespread participation among women in this age group during the past decade has already contributed to lives saved that otherwise would be lost, and that future breast cancer mortality statistics will bear this out. *Importantly, detection of breast cancer at an early stage through mammography screening plays a large role in assuring better quality of life through improved treatment choices, in addition to potential for long-term survival.*

In these public debates over the past year on the value of screening younger women, you have heard those who oppose this practice claim that there is no evidence of a benefit, or in the language of the recent statement from the National Cancer Institute that replaces their previous screening guidelines, "To date, randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50." The attempt at brevity leaves us with a half truth. It would be more accurate to say "It is not possible to have the same degree of scientific confidence about the benefit of mammography for women aged 40-49 as exists for women aged 50-69 due to inherent limitations in the studies that have been conducted to date."

Those who oppose the benefit will then respond that meta-analysis solves the problem of the inadequacy of individual studies. This may be useful in some instances, but these studies are not easily combined due to variations in design, technology, screening interval, the inclusion or exclusion of clinical breast examination and quality. Cost-effectiveness issues are then raised, such as the comparatively lower incidence rate of breast cancer in women under age 50 compared to women aged 50 and older, and the higher ratio of benign to malignant biopsies in women under age 50 who are screened for breast cancer. However, more reasonable comparisons during this debate are for women aged 40-49 and aged 50-59. These differences are not nearly as great.

With respect to this appeal to the sober dispassion of the best and most recent science, it is our assertion that it is not good science to claim with confidence that mammography is not effective in this age group when the research studies to date have been inadequate to answer the questions. It is not good science to say that the needs of women in this age group

will be met if provisions are made to screen those who fall into certain risk categories - we know this will leave the majority of women who will be diagnosed with breast cancer during this period of their lives unprotected. It is also not good public health. Breast cancer represents a significant health problem to women in this age group - it is their number one health concern, and with good reason. Among women aged 40-49, the incidence rate is nearly 10 times that of invasive cervical cancer, and it is the leading cause of death from a single diagnosis. The American Cancer Society is unwilling to dismiss the potential benefit from this examination on the basis of inadequate experimental science, especially when we believe the inferential evidence from these studies and others point to a benefit for many women.

The American Cancer Society can not set these women's needs aside because of our failure to study this question in such a manner that the existing evidence was as definitive, one way or the other, as we have for women aged 50 and older. We believe that women should have access to breast cancer screening at intervals recommended by the American Cancer Society and the majority of medical and consumer groups that have taken a stand on this issue. We believe that women should talk with their providers, should be fully appraised of the evidence, and in that context can reach an informed decision. It is our position that if women chose to be screened with mammography, their provider should not play a gatekeeping role, but rather the role of the facilitator. It is critical that women are assured of timely and thorough follow-up in the event of an abnormal examination and the link to their provider should be primarily for that purpose. The American Cancer Society supports creative methods to pay for these examinations, including co-payments for women who are financially able to contribute to their own health care. We must not, however, deny early breast cancer detection to any woman who does not have the means to pay for the exam.

Finally, we believe that the administration should aggressively support studies of the question of the efficacy of early detection in this age group. The existing trial data are inadequate to provide a definitive answer, and there has been dramatic change in this technology during the 30 year period since the initiation of the first study of breast cancer screening. *These improvements, with appropriate practice guidelines and training for health professionals, can help reduce the number of avoidable biopsies that are performed.*

A majority of women aged 40 and older have ever had a mammogram, and recent data show a steady growth in the proportion of women who report having a recent mammogram. We have implemented special initiatives targeting older women who are at most risk of breast cancer. Great progress has been made in bringing this technology to poor and underserved women, in large part through the efforts of the Centers for Disease Control (CDC) and its breast and cervical cancer screening program that exists now in 45 states. Finally, great progress has been made in the technology and quality of mammography with passage of the Mammography Quality Standards Act of 1992, which will further impact the potential life-saving benefit of this procedure.

The American Cancer Society urges you to build on this progress. Over the years,

we have made great strides in educating women about mammography, breaking down financial, physical and psychological barriers to women seeking mammography to our once universal guidelines. We fear that an unintended and unfortunate side effect of the current debate has been to cause widespread confusion and concern among women and physicians. There is very real concern that existing barriers and negative attitudes towards mammography will be reinforced by this conflicting and negative attention, and that this might drive women of all ages away from a confidence in mammography as today's most important means of fighting this deadly disease.

The economics of health care have become another important and undeniable aspect of all issues such as the one we are discussing today. Policy makers are struggling with the desire to match the availability of health care with those populations who need it most. We believe that ALL lives that CAN be saved with this lifesaving tool of mammography SHOULD be saved.

In addition to the progress that has been made with existing technology, there are exciting new developments emerging in genetic markers and different modalities of imaging. We need to pursue the existing questions and new questions aggressively, and the American Cancer Society believes that women should not be denied access to this technology during these investigations. We strongly endorse that routine mammography be made available to women between the ages of 40-49 and that the Administration support an aggressive research program related to improving the application of existing technology and emerging technology to identify women with breast cancer and those at risk of breast cancer. We also strongly endorse that this program not be at the expense of research targeted to prevention and cure of breast cancer, or other critical research programs.

In conclusion, the American Cancer Society strongly disagrees with any change in reimbursement for mammography screening at this time, based on existing studies, and calls on Congress to make mammography available to all women at the frequency intervals recommended by the American Cancer Society. Mammography offers strong potential to save lives from cancer and if detected early, provides a woman with increased options for treatment and improved quality of life. Under health reform, the American Cancer Society believes that routine mammography should be available on a routine basis to women over the age of 50 on an annual basis with no cost-sharing, and for women age 40-49, every 1-2 years based on risk and other factors discussed between the woman and her physician. Breast cancer is a major problem for all women, including women aged 40-49, and they should not be left without access to this procedure. Finally, the flexibility indicated by the Administration for screening women of all ages, must not be left to the determination of individual health or corporate alliances, but should be standardized in guaranteed minimum benefits. Clinical breast examination and instruction in breast self-examination are integral components of breast health care and should be available to all women at age intervals recommended by the American Cancer Society.

Thank you.

Mr. WAXMAN. Ms. Visco.

STATEMENT OF FRAN VISCO

Ms. VISCO. Thank you, Chairman Waxman and Mr. Towns, and other members of this subcommittee for holding this hearing and for inviting us to testify.

I am Fran Visco. I am a breast cancer survivor and I am president of the National Breast Cancer Coalition. The coalition is a national grassroots advocacy movement dedicated to the eradication of breast cancer. Our members number more than 240 organizations and thousands of individuals from across this country. Our coalition's goals are to increase the funding for breast cancer research and to focus on finding a cause and a cure to improve access for all women to the treatment and care that they need and to increase the influence of women with breast cancer on the decisions that impact their lives.

I want to thank the members of this committee for their support in helping us have the first significant increase for breast cancer research last year.

We know the statistics. There are 2.6 million women living with this disease today in this country. Since 1960 more than 950,000 U.S. women have died of breast cancer. That number is more than two times the number of combat deaths of Americans from World War I through the Persian Gulf War. We estimate 46,000 women will die this year.

A disproportionate number of these deaths will be of African-American women who are diagnosed less frequently with the disease but who die at a greater rate. We believe that is because they do not have access to high quality care.

Today I am here to address some of the broader implications of health care reform. We can debate the appropriate intervals and ages for screening mammography. But we must keep the big picture in mind. All 2.6 million women living with breast cancer need comprehensive health care reform and we need it now. We need universal eligibility, universal coverage, and universal access.

For the 183,000 women who hear their physicians say to them this year, "You have breast cancer", they must know they have access to quality care. They must know that the fact that their disease will not keep them from the jobs that they want, will not keep them locked into jobs, and will not keep them from getting insurance.

Real health care reform will wipe out preexisting exclusions. It will have a comprehensive basic benefit package. All the debate about how often and at what age women should receive free preventive coverage is an academic exercise if there is not a defined, basic benefit mandated that includes mammography.

Real health care reform must cover participation in clinical trials and investigational studies and the care attendant to participation. Right now many insurance policies do not cover those costs and they limit participation into potentially lifesaving trials to women who can afford to pay and they keep us from the evidence we need upon which to base our coverage decisions.

If we are going to cover what works, we have to pay to find out what works.

President Clinton's Health Security Act pending before this committee meets the standards of the National Breast Cancer Coalition as I have articulated and so does the Single Payer legislation introduced by Representative McDermott. Not all of the bills pending before this committee do.

If the legislation does not meet these minimum standards, it will not receive the coalition's support.

Once we agree on the key components of health care reform for women, we can then address specific questions, specific concerns about mammography. First I want to applaud the administration for including screening mammograms in the health care reform package because many insurance policies do not cover it.

If the bill was enacted as it exists today, more women would have access to screening mammography than ever before. We have heard strong concerns from many about who to screen and how often. Let's be consistent. For women over 50, the Board of Scientific Counsellors recommended to the National Cancer Institute that these women be screened every year, not every other year.

My understanding of the revised guidelines from the National Cancer Institute is that women over 50 should be screened every year, not every other year. Every other organization believes and follows that mandate.

What we heard this morning was we do not have evidence between 1 year or 2 years. We don't know. But the statistical analysis performed within NCI shows that if we screen women every 2 years rather than every 1 year, we lose more women to breast cancer. That is for women over 50.

For women under 50, no one believes that it is as effective for younger women as for older women. But does it find breast cancer? Yes, it found mine when I was 39 years old by a screening mammogram. I had surgery, chemotherapy and radiation. What they are saying to you is that we cannot prove that saved my life. We just don't know. We don't have the evidence. The experts dispute that.

Well, let's find out. Let's put the money into finding out what does work best for younger women.

You heard Dr. Broder this morning talk about MRI's and digital mammography. But those tests have to be put through trials in order to determine if they will work. We are only going to cover what works. We need to commit the funds to finding out. The coalition wants every woman in that age group put into a national system of randomized clinical trials, testing different modalities of screening to determine what does work best for this age group.

As new techniques are developed, they can be folded into the trial design. Under the Clinton proposal and any meaningful health care reform proposal, participation in the trials will be covered. This is what we need to do.

Let's just stop the debate and spend the money and get the answers.

Mr. WAXMAN. Thank you very much, Ms. Visco. Your written statement will be in the record.

[The prepared statement of Ms. Visco follows:]

STATEMENT OF FRAN VISCO

Good morning, I want to thank you Representative Waxman and the Subcommittee on Health and Environment for holding this important hearing on the impact on women's health of the Health Security Act and for inviting me to testify.

I am Fran Visco, president of the National Breast Cancer Coalition (NBCC). I am pleased to have the opportunity to share with you our thoughts on the implications for breast cancer patients and survivors of the Clinton health plan and in particular, the mammography standards.

First I would like to take a few moments to describe to you the organization I represent. The National Breast Cancer Coalition is a grassroots organization conceived in January 1991. Since that time, the Coalition has grown to more than 250 organizations which represent thousands of patients, their physicians, families and friends whose primary focus is the eradication of the breast cancer.

Our coalition's goals are (1) to increase the funding for breast cancer research with an emphasis on finding the cause of and a cure for this insidious disease; (2) to make certain that all women have access to quality care and treatment and (3) to increase the influence of women with breast cancer in the decision making that affects their lives.

Since 1960, more than 950,000 U.S. women have died of breast cancer: this staggering number is more than 2 times the number of Americans who died in combat during WWI, WWII, the Korean, Vietnam & Persian Gulf Wars combined. 46,000 will die this year. A disproportionate number of these deaths will occur among women of low income, many of whom belong to a minority group and are underinsured and uninsured. Too few women have access to high quality care. In breast cancer research, there has been little progress in methods of detection and treatment over the past twenty years.

Today I want to address some of the broader implications around the health care reform for women with breast cancer and to implore this Committee to report out comprehensive legislation that will meet their needs.

As the debate about the appropriate population and intervals for screening mammography rages, the NBCC believes that it is important to keep the "big picture" in mind.

All 2.6 million women living with breast cancer need comprehensive health care reform now and for the rest of their lives. They need insurance that cannot be taken away...ever... for any reason.

For the 183,000 women next year who will hear their physicians say these dreaded words -- "you have breast cancer" -- they need to know that they will have access to quality care. Quality health care for all -- regardless of employment, health or marital status -- must be available. Real health care reform must guarantee that every woman has access regardless of her economic status. Currently, women who are uninsured can wait long periods of time for treatment of breast cancer; their chance of survival diminishes as their wait increases. The data from the African-American community makes this point in very stark terms. Although fewer African-American women are diagnosed with breast cancer, a larger percent die from this disease. We believe that the failure of the health care system to afford early detection and state-of-the-art treatment to under-served women is the major reason that African-American women die in disproportionate numbers from this dread disease.

Real health care reform wipes out pre-existing condition exclusions. This is imperative for the 2.6 million women who are living with breast cancer. Women with breast cancer and their families should no longer be locked in jobs only to maintain health insurance -- nor should they lose their health benefits if they lose their jobs. Employers should not be afraid to hire them because of the high cost of insurance. The travesty that breast cancer patients are denied health insurance coverage -- because of the very fact of their disease -- must end.

Real health care reform has a comprehensive basic benefit package. All the debate about how often and at what age a woman should receive free preventive coverage is an academic exercise if there is not a defined basic benefit mandated that includes mammography. Currently, many women over age fifty do not receive any reimbursement for screening mammograms.

Real health care reform must cover medically appropriate care when it is provided as part of an approved clinical trial. Right now, many insurance policies do not cover these costs -- thereby limiting the participation in potentially life-saving clinical trials to women who can afford to pay.

President Clinton's Health Security Act, pending before this Committee, meets the standards of the National Breast Cancer Coalition as articulated above -- and so does the single payer legislation introduced by Rep. McDermott. Not all of the bills pending before this Committee do. If the legislation does not meet these minimum standards it will not have the support of the NBCC. If it does not meet these minimum standards it will not matter how frequently and at what age women can get screening for breast cancer.

Once we agree on the key components of real health care reform for women concerned about breast cancer, then we can address specific questions.

Now -- our specific concerns about mammography. First, I want to applaud the Administration for including screening mammograms in the benefits package. As you know, many insurance companies now do not reimburse for screening at any age or at any frequency. The inclusion, even if limited, is a very positive step in the right direction.

As you know, strong concern has been raised from women's health advocates and from women Members of Congress about the health plan's proposed limitations on coverage of mammography -- the Administration proposes to limit coverage because there are very real questions about the efficacy of screening mammograms for women of different ages and for screening at different intervals.

It must be kept in mind that the scientific data did not exist to justify the national consensus guidelines when they were created. It is the assessment of the NBCC that we simply do not have enough scientific data to make a decision today to limit availability of these tests. As part of my testimony, I will not take the time to present the scientific evidence, or lack thereof.

These facts have been presented by others. I will use my time to present the NBCC position:

"Realizing that mammography does not prevent breast cancer and that much of the available data are INCONCLUSIVE, we support:

- Breast cancer screening guidelines based on data from randomized clinical trials.

In order to gather data on the efficacy and appropriate timing of screening over the spectrum of age groups, we demand:

- That all screening be done through a system of randomized national trials.

Because it has been shown that screening mammography is efficacious for women between the ages of 50 to 70, we believe

- That national trials shall include but not be limited to randomizing women in this age group into screening programs that screen at least with mammography at different intervals.

As the current screening data is INCONCLUSIVE for women under 50, we believe:

- That national trials must examine the efficacy and timing of different screening techniques.

There is NO data on screening for women over 70, and therefore, we believe:

- That a variety of screening methods and their timing should be studied.

Until such time that a trial is available to every woman, we demand:

- That every woman should be eligible for screening under the current (September 20, 1993) national consensus guidelines."

But there may be a silver lining created by all this ruckus about mammography, its efficacy and frequency, as well as of its coverage. Public policymakers are becoming painfully aware of the inadequacy of mammography as a screening technique. For the past ten years, mammograms have been incorrectly referred to as prevention, even by people who should know better. This has led to a false sense of security. Mammography does not prevent breast cancer -- it is a diagnostic tool that may prevent mortality in some cases when followed by appropriate treatment. If the data cited by the Clinton Administration and the National Cancer Institute are correct -- that mammograms for women under age 50 are not efficacious -- then what is available for these women? Breast cancer is the leading cause of death for women ages 35- 52. What do we tell these women to do? Hope? Pray?

Our public education campaigns in recent years have lulled women into a false sense of security: if they get their mammogram, and find an "early" cancer there is a 90% "cure" rate. The data actually show that there is, in some instances, a five year survival rate, but the women are not necessarily cured. Mammograms cannot detect all breast cancers.

Breast cancer exists for 7 or more years before it is detected by a good quality mammogram. The NBCC has urged for the past three

years that we need better screening techniques. We need a blood test! We need to identify early markers!

All of this is yet another graphic illustration of how the health of women suffers because not enough research attention has been dedicated to women's health needs.

Our other difficulty with proposals regarding mammography has to do with reimbursement. Currently the Clinton plan will expand full reimbursement for mammograms for high-risk women, if the mammogram is recommended by their physician.

Only family history and age have emerged as truly significant risk factors -- all others are only marginal. Nearly all women carry some risk for this disease. How will their breast cancer be detected? Will it be too late?

It is likely that only very motivated "high-risk" women will be assertive enough with their doctors to insist on receiving a mammogram. Mammograms will be available for other women, if recommended by their doctor, but the women will have to pay part of the cost. What will be the result for poor women?

This debate on these guidelines has made it painfully clear we lack a good means of early detection of breast cancer. As we all work together on this particular aspect of the Clinton plan -- screening once every year or every two years, what age, etc. -- we cannot afford to lose sight of the bigger question: how can we marshal our resources to look for new methods of detection? discover the causes? find a cure?

In conclusion, the National Breast Cancer Coalition is committed to work with you, Mr. Chairman, and the other Members of the Committee to ensure that real health care reform is passed this year. This is a priority of the National Breast Cancer Coalition. We intend to work very hard at this goal as we have done in the past.

In 1991, we generated 600,000 letters to Congress and the President to increase the funding for breast cancer research. Since then, money for research has quadrupled.

In 1993, we delivered over 2.6 million signatures to the President in the East Room of the White House requesting the creation and implementation of a national strategy to eradicate breast cancer. In response, under the leadership of Secretary Shalala, over 120 activists, scientists and public policymakers have crafted a short- and long-term strategy.

This year, our grassroots will mobilize so that the 2.6 million women who have breast cancer, and the millions of other women who will be diagnosed in their lifetime, will have access to quality health care that can never be taken away. We have read news reports that Americans are longer concerned about health care reform. I want you to know that for the women living with breast cancer there is still a health care crisis and there will be until Congress enacts comprehensive health care reform. This year provides an incredible opportunity to truly reform the system. We cannot let the chance slip away; we must make it happen.

Mr. WAXMAN. Dr. Curd.

STATEMENT OF JOHN CURD

Mr. CURD. Good afternoon, Mr. Chairman. I am John Curd, clinical director at Genentech. I am going to discuss breast cancer and our progress in the development of new products for the treatment of this disease.

As we have heard today, women's health in general, and breast cancer, in specific, have been disproportionately underfunded and underserved.

We at Genentech and others in the biotechnology industry are on the verge of producing novel products which will alter the course of breast cancer.

Ironically, Mr. Chairman, at this very time our progress towards better treatments, or possibly even cures, for breast cancer and other women's diseases is threatened by the possibility of price controls.

As a physician and a scientist, I am surprised, and personally embarrassed, by our record in women's health. Our study of women's diseases as well as our knowledge of the responses of women to commonly prescribed medications is inadequate and certainly troublesome.

Breast cancer, the most common cancer in women, is increasing in incidence for unclear reasons. Today more than 10 percent of women will experience breast cancer and many will die from it. Despite 20 years of hard work of countless physicians, scientists, and care givers in the areas of early diagnosis, surgery, irradiation, and chemotherapy, the mortality from this disease is essentially unchanged. Clearly our progress in this area is unsatisfactory.

In the past few years we at Genentech in collaboration with Dr. Dennis Slamon at the UCLA Medical Center—Mr. Chairman, I believe you are acquainted with this excellent institution—have made dramatic progress in the development of a new way to treat breast cancer.

Prior research identified a gene strongly associated with—the development of brain tumors in rats. This gene was called the “new oncogene.” Dr. Slamon showed that the human equivalent, called the “Her-2” gene was overexpressed in about $\frac{1}{3}$ of women with breast cancer and was associated with rapid progression and early mortality. The gene is also associated with ovarian cancer and stomach cancer. Patients who have cancer with this gene die in about $\frac{1}{2}$ of the time as patients without it.

Dr. Slamon and his colleagues reasoned that the Her-2 gene was important in the growth of breast and ovarian tumors and that specific antibodies to the Her-2 receptor would inhibit or slow growth. He and his colleagues performed experiments in tissue culture and in animals with mouse monoclonal antibodies to establish this hypothesis.

In order to study the effects of an antibody to the Her-2 receptor in women, it was necessary for Genentech scientists to engineer a “fully humanized” anti-Her-2 were transferred to a human framework antibody that grows in the cultured mammalian cells commonly used to make recombinant human proteins. The humanized antibody has been administered and tested in about 80 women

with resistant breast or ovarian cancer. The remarkable result is that the bioengineered antibody is completely compatible with chronic administration to humans and has a very favorable safety profile when compared to other cancer therapies. The preliminary efficacy evaluations are very encouraging and further clinical development is likely.

At this point, I would like to make a personal comment as a scientist. As short a time as 3 years ago, I believed that the development of a fully compatible humanized antibody was impossible. The lesson here is that biotechnology is making today's dreams tomorrow's realities. Genentech is not alone in what it is doing in biotechnology for breast cancer. Other equally exciting strategies are under development at Mederex, Chiron, and Amgen, to name a few.

The story of Her-2 and the evolving history of biotechnology reminds me of the history of the discovery of antibiotics. The chemists who first synthesized PABA or sulfa did not know that they had discovered antibiotics. Little could they imagine what would follow. Today, I am confident that someone in biotechnology is developing the products that will dramatically alter the way physicians treat breast cancer, other cancers, and other common incurable diseases like osteoporosis, Alzheimer's disease, and perhaps even AIDS.

Mr. Chairman, we are at the breaking of a great new dawn in the treatment of human diseases. Our resource is the human genome and the vast information it contains in regard to human biology. The biotechnology industry is poised and ready to convert our expanding understanding of biological processes into real products with real value in treating women's diseases.

Paradoxically our rapid progress toward novel treatments and cures is threatened by the possibility of direct or indirect price controls. Our industry was born by and is nourished by investment. The funds to support clinical development in my industry comes from investors. Investors are concerned about risks and returns.

Mr. Chairman, the unintended consequence of lowering returns through price controls will be to drive investors to lower risk leading to more "Me Toos" and less "Her-2s." Our rapid progress towards those novel treatments and cures will be slowed. Women with breast cancer and patients with incurable diseases will continue to suffer. We cannot allow this to happen.

Mr. WAXMAN. Thank you.

[Testimony resumes on p. 257.]

[The prepared statement of Dr. Curd follows:]

STATEMENT OF JOHN CURD

Health care reform has profound implications for the treatment of many serious unmet medical needs, including virtually all of the diseases and conditions affecting women in the United States. Because of the chronic disproportionate underfunding of women's health research and the lack of appropriate attention and resources being applied to women's health issues, there is a greater need to look forward to potential cures and treatments in this area of medicine.

Biomedical research and its application through biotechnology into new drugs, devices, diagnostics and biologics offers vast new opportunities in the treatment of women's health issues. In its consideration of health care reform, Congress should be cognizant of three points:

- * High technology medicine -- including biotechnology-derived products -- is inseparable from health care. It is not an add-on to health care; it is an integral part of health care.

- * The single most important step to improve women's health care -- outside of behavioral changes -- would be to bring to fruition the work currently underway in America's biotechnology firms.

- * Finally, health care reform should foster the innovative spirit of the medical technology industries. The biotechnology industry's track record has been at the creation of at least one novel, breakthrough product every year since the last decade. This can best be done by creating a marketplace that rewards new products for serious unmet medical needs and works towards

reducing total health care costs. Setting up real or disguised price controls will not stimulate innovation.

BREAST CANCER: A CASE STUDY

During the testimony to be presented today, the Committee will hear expert testimony about a variety of women's health issues. This testimony includes a review of the medical situation with respect to the treatment of breast cancer. Through this testimony we hope to demonstrate the following:

- * Little progress has been made in the treatment of breast cancer in the past 20 years.

- * Much of the new science that offers great promise for treating breast cancer has grown out of our expanded understandings of the human body as the result of research by the government (both at the National Institutes of Health and its grantee universities) and the private sector.

- * The best hope for applying that knowledge and finding new cures and treatments comes -- not just from government research but -- from the entrepreneurial, and innovative sector of the private sector, especially the biotechnology industry.

- * Finally, if direct or indirect price controls are imposed on the risky breast cancer research that we and other companies engage in, there is likely to be less of that research and thus fewer cures and treatments.

BACKGROUND ON BREAST CANCER AND BIOTECHNOLOGY

What our industry is doing is novel and important because it opens up many new approaches to therapy that are not available through traditional drug development. Just as the discovery of sulfa compounds opened up a new door toward the development of antibacterial products to treat infectious disease, biotechnology is providing the needed paradigm shift to provide new approaches for today's major medical disorders, especially in women's health. The potential is as vast as the human genome.

This is good news for health care in general and for those concerned with diseases affecting women specifically, and I will give specific examples relating to breast cancer.

Breast cancer is the leading cause of cancer among women. Although lung cancer now kills more women, the prospect of breast cancer can be more frightening because, unlike lung cancer, there is no one voluntary act an individual woman can take to cut her risk sharply.

Breast cancer has registered a 21 percent increase in incidence between 1973 and 1989 while its mortality rate has held constant. If ever there was a disease in need of a paradigm shift for therapeutic approaches, breast cancer is it. We have virtually exhausted the potential of traditional chemo- and radiotherapeutic approaches.

Biotechnology firms are well-positioned to develop new breast cancer treatments thanks to advances in the basic scientific understanding of what triggers tumor development and

metastasis or movement, how cancer cells grow and spread, and how cancer cells differ from normal cells. Although there is much we do not know, what is known has allowed us to create a new class of treatments for breast cancer and probably many other cancers as well.

Breast cancer cells pour out several growth-stimulating proteins. Early on, researchers discovered the existence of "oncogenes" or cancer genes. In rats, one of these has been shown to promote the formation of a tumor. Specifically, neuroblastoma; hence it was named "neu". Several years ago, researchers at the University of California at Los Angeles (UCLA) led by Dr. Dennis Slamon found that breast cancer cells from some women with rapidly progressive cancer had extra copies or an overexpression of this neu-gene, also called HER2. These cells then overproduce the HER2 protein, a receptor for growth factors. Hence, these cells grow more rapidly than cancer cells from breast cancer patients that don't overexpress the HER2 protein.

Researchers hypothesized that if these receptor sites could be blocked by an antibody, the growth factors would be unable to attach to or stimulate the cell. As a result, the cell's growth would be inhibited and maybe even slow down. This hypothesis was verified in animal models and tissue cultures.

The UCLA researchers, in collaboration with Genentech, used mouse antibodies against HER2 sites in an early clinical trial. The results appeared promising. However, because all mouse

antibodies trigger a strong human immune system response within two weeks of administration, they can be used only once.

Alas, current technologies cannot make human antibodies. Fortunately, we do have the technology to create a "humanized antibody"; an antibody in which all but the antigen-recognition portions of the molecule are replaced by human antigen sequences. Hiding, or actually diluting, the presence of mouse sequences slips them past the body's immune defenses. Genentech produced a humanized HER2 antibody, a product compatible with long-term administration that has already been shown to induce few side effects.

Exactly a year ago the Slamon group undertook a multiple-dose "Phase I" clinical trial with this humanized antibody. To date, this has included approximately 100 women with breast cancer which had been progressive despite all other forms of treatment. The most important result so far is that this engineered antibody has been accepted by every one of these women, even after chronic administration over months, with no side effects or immune reactions whatsoever.

We are now completing the first Phase II trial, which expands the treatment group to further assess safety and to also assess activity. Preliminary data from this trial is promising. If the results show success in reducing tumor size in a significant number of women, we plan to begin a large Phase III double-blinded trial by 1995.

Other biotechnology firms are using similar techniques to produce tumor-inhibiting molecules which use a different action to attain a similar end. For example, Medarex's "bispecific" product against breast and ovarian cancers, called MDX-210, consists of fragments of two monoclonal mouse antibodies linked together. These tag cancer cells that bear large numbers of the HER2 protein as foreign, triggering the patient's immune system to destroy them. Medarex is considering developing a humanized antibody. In another Phase I trial, sponsored by Chiron Corporation, a different "bispecific" antibody has shown immunologic activity against cancers at many sites.

Another class of genetically-engineered drugs acts to inhibit the growth of blood vessels by cancer cells, thereby preventing cell growth and spread throughout the body. Currently there are several on-going Phase I trials, including one by Marc Lippman of Georgetown University School of Medicine, using such drugs against various cancers.

These are exciting examples for women facing breast cancer in the next few years. But I am convinced these examples are but a few small steps in what can be many tremendous strides by this industry and biomedical technology toward treating -- potentially even curing -- breast cancer, other cancers, other diseases affecting women, and the many diseases effecting human health in general. If you truly want to improve women's health, you must nurture this potential.

BIOTECHNOLOGY'S STORY

The biotechnology industry has developed breakthrough treatments for disorders such as: diabetes, cystic fibrosis, heart attacks, leukemia, growth retardation due to various medical causes, anemia resulting from kidney dialysis, multiple sclerosis, and a vaccine for Hepatitis B.

It offers the best potential for treatments, preventions and cures to costly and devastating disorders like: AIDS, cancer, genetic disorders, Alzheimer's and Parkinson's disease, and allergies, asthma and rheumatoid arthritis.

In fact, the biotechnology industry offers the best hope for controlling health care costs in the future, because medicines are the single most important source of cures and effective disease treatments and because biotechnology has the potential to find such treatments quickly compared with traditional methods.

Biotechnology is addressing devastating diseases for which there is currently no effective preventatives, treatments or cures, and this medical gap is costly.

HEALTH CARE REFORM: RISKS AND OPTIONS

The biotechnology industry understands that the nation faces a severe health care crisis. We want to be part of the solution, and we are heartened that the Administration, and other reform framers, have reached out to the biotechnology industry for input in the process of working on these important reform issues.

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Many in the biotechnology and pharmaceutical industries share many of the same goals that have been articulated for national health care reform, including universal access, and a pharmaceutical drug benefit.

We also agree on some of the means for achieving reform's goals; increased availability of information and benefits and efficacy of available treatments (such as better outcomes research and medical practice guidelines). Together these will lead to more appropriate use of technology and increased use of breakthrough treatments that offer the greatest benefits to patients.

But we believe that the Federal government should analyze data about all modes of treatment, including procedures, devices, drugs, biologicals and diagnostics. And, that the Federal government not distinguish between old and new technologies, as is only logical. For example, it wouldn't make sense to exclude prostate cancer screening from possible priority review by the Federal government because the diagnostic tool is "old." Thus, we do not support the Administration's "breakthrough drug committee."

It should be noted that the Cooper/Grandy and Breaux/Durenberger bills on health care reform contain very positive treatment of technology as an integral part of modern medicine. They set up a positive structure to evaluate all procedures, devices and drugs and they avoid discrimination against new technology. This is important, because

discriminating against new technology would stifle innovation, and innovation is our best hope to continue to increase the value of medical care.

On the use of technology, we believe local providers -- in consultation with local plans and "health alliances" -- should make decisions about whether to use a particular technology based on information developed and disseminated by the Federal government, functioning as described above. Under managed competition, each plan would have a strong incentive to let the market determine the utility and use rate of every type of treatment being applied in the marketplace. The cost containment results we all seek would be driven by market forces that would motivate each plan to offer high quality care at a low price, and plans would not include the use of expensive technology unless there is a benefit to the quality of care -- unless there is value -- offered by the plan.

Two elements of the Clinton plan pose danger for the biotechnology industry. Price controls, even if they are not openly called such, and excessive rebates for Medicare patients. These provisions of the Administration's plan pose a serious threat to this capital-driven industry.

The biotechnology industry has much to consider in determining prices. Besides research, development and manufacturing costs, we must consider the cost of the many molecules that don't make it to market or don't yet provide profits, the costs to plow back into R&D to continue developing

breakthrough drugs, and the need to attract investors in a high risk environment, as well as the value the drug brings to patients.

We have established a strong record of selling drugs in the United States at the same price or at a lower price than they are sold in other industrialized nations. Raising prices on existing drugs has not been a practice of this industry. The biotechnology industry has a track record that will assure that future price increases will be limited to -- or below -- the rate of inflation. In exchange, we ask for the opportunity to continue to set introductory prices in accordance with the need to provide equity investment in our industry, and in accordance with the value the drugs we produce offer.

There is a trend toward lower price increases in any case because managed care organizations are requiring manufacturers to document the cost-effectiveness of their products and offer low prices to gain entree to their formularies. Again, returning to the idea of value in the context of discussing the costs of health care, it is absolutely crucial to consider what our health costs will be when baby boomers reach their most disease-prone years if we still haven't found treatments for such expensive diseases as Alzheimer's, Parkinson's, cancer and AIDS. Price controls on introductory pharmaceuticals would undermine the very industry that offers the most promise for finding these important solutions. The value breakthrough pharmaceuticals could bring in eliminating or alleviating these and other diseases is as yet incalculable, but will surely be tremendous.

Let's make sure we set the conditions so that we can use technology to realize this sort of medical value as quickly as scientific progress will allow.

Thank you. I'll take questions.

Mr. WAXMAN. You two have expressed disagreement with the National Cancer Institute change in recommendations. Do either of you believe NCI made this recommendation on any basis other than the science Dr. Broder laid out in his testimony?

Mr. CURD. Congressman Waxman, I don't believe they did. I believe they based it purely on the criteria that they want to apply for scientific judgment in this case. They are correct in saying that this initiative began long before the debate about providing mammography under the Health Security Plan.

Mr. WAXMAN. Dr. Alley, there are cases of women who get breast cancer in their 30's. Why doesn't the Cancer Society recommend routine mammography for women under 40?

Ms. ALLEY. Because the incidence really strikingly increases after the age of 40. So there are few reported cases under the age of 40. But as I said, the incidence strikingly increases after the age of 40 and continues to increase after that.

Mr. WAXMAN. So the question we have to confront here is when do we provide something routinely and for free and when is the investment's return so low that the money would be better used in other services.

The American Cancer Society believes that while the data are incomplete, we should continue to provide screening that some studies say are not worthwhile.

Other reputable scientists disagree. How do you recommend that people who have to pay for these benefits draw the line?

Ms. ALLEY. I would think they draw the line where it has been drawn in the past. In other words, these recommendations have been in place for a number of years and examined not only by the American Cancer Society but as I mentioned a number of other organization also, the American College of Obstetrics and Gynecology, the American Medical Association.

We have all looked at these studies and seen that while perhaps it is not statistically proven in this particular age group, the studies have suggested that it improves survival and to recognize that a larger study perhaps needs to be done in this age group, but not to eliminate mammography just because there have not been enough studies done so far to show that it is statistically different in that age group.

Mr. WAXMAN. Mrs. Visco, you recommend that a trial be conducted on the effectiveness of mammography in women of different age groups. How long do you think such a trial would take?

Ms. VISCO. Our recommendation is to study not just mammography, but different screening modalities. For example, the NCI recommends clinical breast exam, but there are no trials showing the efficacy of clinical breast exam. We have no idea how effective that is, although it is covered under the Clinton health care reform proposal.

We want a trial of different screening modalities of women. I am told it will last a very long time. But if we are going to base our decisions for reimbursement on what works, I don't see what our choice is. I think we have to provide the trials to get the answer to what works. We have to make certain that the participation in those trials are paid for.

Mr. WAXMAN. You said that the NIH has performed statistical analyses on the difference between screening mammography annually versus every 2 years, and that the analysis shows improved outcomes of screenings annually.

I will ask Dr. Broder to respond for the record, and I would ask you to submit your backup material also, if you would.

Dr. Curd, we certainly wish you the best of luck in pursuing your answer to this breast cancer. We would certainly want to see that breakthrough. I appreciate what you had to say.

Mr. Towns.

Mr. TOWNS. Thank you, Mr. Chairman. I am concerned that if we eliminate mammography from the health care package, we will leave tens of thousands of women just floating in a vacuum until after 50 years of age.

The science today is unclear whether mammography reduces mortality rates in women under 50. We must begin researching immediately what screening methods work for these women.

I support the idea of enrolling every woman between the age of 40 and 49 with a national insurance card containing all of her data into a national system of randomized clinical trials to test all different kinds of screening methods from mammography to ultrasound. And this screening will be covered under the plan.

If we do that, then we will not be compromising the health services of women. I think we have to be concerned about that. Within 10 years we will know what screening methods actually work.

Can I get your views on that?

Ms. VISCO. That is exactly the position that the coalition hoped you would take, and other Members of Congress. That is certainly what we want to see done.

I truly can't imagine what else we can do. If we are going to start basing our coverage determinations on evidence bases, then we have to get the evidence. Because if a week from now or a year from now someone comes along and says we have a blood test that detects breast cancer, well, to carry through the NCI's philosophy, they will not recommend it, and health care reform will not cover it because we really have no evidence that it saves lives.

We have to get the evidence and you are absolutely right, that is the way we need to do it, by enrolling every woman in that age group in a national system of randomized trials, we are protecting women and we are protecting our resources.

Mr. TOWNS. What do you think the opposition would be? This is something for the budget cutters. They should be on our side.

Ms. VISCO. The difficulty is that it is going to cost a lot of money and take a long time. I believe the American Cancer Society had the same response.

Ms. ALLEY. I think the difficulty is in designing the study. The other difficulty I see is if you are talking about randomized trials, you are talking about controls and those are women who are not going to get screened.

I don't know how the study design would occur so you are not somehow having a group of controls that are not going to get screened.

Probably, we were discussing this earlier, it would take as many as 250,000 cases before you are going to have enough positive results to come up with a statistically significant difference again.

There are a couple of things I would like to point out about looking at these older studies and for instance the Canadian study that was quoted by Dr. Broder. First of all, I think most scientists and physicians agree that the Canadian study was not a valid study for a number of reasons.

One thing I would like to point out is that mammograms are getting better and better. I look at a mammogram now and compare it to a mammogram that was not even 3 or 4 years ago. The technology has improved vastly.

The other things that are available are other tests that can be adjuncts to mammography so that every woman who perhaps has an abnormal mammogram does not end up with a biopsy.

There are, as you mentioned, ultrasounds that can be done to aspirate a cyst or a newer technique called stereo-mammography where a biopsy can be done with a needle without involving surgery. So there are a lot of new techniques available that I think are important to consider.

I just think it would be a real mistake to say well, we don't have the data so we are going to eliminate mammograms, not that it should not be done in conjunction with clinical exam, self-examination, and other methods of detection.

Ms. VISCO. Mr. Towns, I have been told by a number of scientists that it is possible to design such a trial. I would be happy to present you with the information that I have from them.

Mr. TOWNS. Thank you. We would be delighted to receive it. Every now and then I think about the fact that this could be presented in a cost-saving kind of way when we look at terms of what we would do in the long run in terms of early detection and all the kind of things, in other words, that kind of cost saving. Is it possible for me to make that argument?

Ms. ALLEY. Absolutely. You know, you save a lot of money when you find breast cancer when it is at a pre-invasive stage and it does not require chemotherapy. That saves a lot of money, not only in terms of chemotherapy, but in terms of days lost at work, days lost at being a mother. So certainly you can save money.

The other thing I might mention is when you talk about covering mammograms if it is ordered by the doctor for a reason, that is called a diagnostic mammogram. In Washington, DC. they charge about \$125 for that. If a patient goes in for a screening mammogram, that is \$65.

Mr. TOWNS. Mr. Chairman, I know my time is up. But I really think that is an argument we need to make. Sometimes when we look at these kind of matters and we look at saving a dollar today, not looking to what we would save down the road.

In other words, they call this in Brooklyn, where I come from, they call this hustling backwards.

Mr. WAXMAN. Thank you, Mr. Towns.

I want to thank the panel as well. You have given us terrific testimony. We will share it with our colleagues on the committee. The hearing is adjourned.

[Whereupon, at 3:05 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted for the record:]

ADOLESCENCE AND HEALTH CARE REFORM

Robert Wm. Blum, M.D., M.P.H., Ph.D.

My name is Robert Blum; and I am a Professor of Pediatrics at the University of Minnesota where I direct the Division of General Pediatrics and Adolescent Health. I am a parent of three children, two of whom are adolescents, and the other a teenager-in-training. I have recently served as President of the Society for Adolescent Medicine and while I speak for myself today, I know that the ideas I present reflect the opinions of many of my colleagues. I speak to you as a clinician, as an educator, a parent and one vitally interested in the implications of health care reform for the health and well being of young people. The suggestions I will offer are based upon a recent working group meeting held in Washington where the focus was on adolescence and health care reform.

Adolescence is a unique developmental stage distinct from both childhood and adulthood. Not only is it a transitional period, it is a life stage with special vulnerabilities and health concerns. While we tend to focus on major public health problems such as juvenile violence, sexually transmitted diseases including AIDS, substance abuse and precocious parenthood, youth are faced with a much wider set of health risks. Six percent have chronic or disabling conditions that limit their activities of daily living. One in six will experience significant depression with nearly 15% of teenagers attempting to kill themselves at least once during their adolescent years. This is also the age group with the most rapidly escalating levels of poverty of any in America.

Equally important to the problems facing youth is the reality that adolescence is a time of opportunity. It is the stage of life when many health habits are being formed—habits concerning tobacco use, alcohol use,

nutrition and exercise are but a few examples which can relate to severe and costly adult health problems if health promoting habits are not instilled early. Likewise, stress management, conflict resolution and assertiveness skills while not ostensibly health concerns rapidly become so when we look at the litany of morbidity and mortality that stems from our failure to address those issues: depression, chronic pain, suicide, homicide, intentional injuries, child abuse, pregnancy and sexually transmitted disease are but a few. These are profoundly costly and to a great extent avoidable social morbidities in adolescence and adulthood.

The Clinton Health Security Act appropriately places its emphasis on preventive and health promoting strategies. The universal coverage provision and the basic benefit package with its focus on primary care services for youth as well as for all Americans emphasize health care provision where it most appropriately belongs — in the primary care setting. However, given both the unique needs as well as opportunities of this age group the following recommendations are offered.

#1 Financial Barriers

Financial barriers to services — especially preventive and primary care services — are counterproductive. Given the vulnerability teenagers already feel in seeking services, financial barriers will only perpetuate the inherent inclination to delay seeking care. For those in poverty — 20% of the adolescent population — this is even more problematic. Thus, I would recommend: a) the co-payment requirement should be eliminated for those below 200% of poverty; b) co-payments by adolescents be eliminated for those services protected by federal or state statute as confidential; and c)

co-payments should be adjusted for total use and not solely episodic visits so as to account for the long-term care needs of those with chronic and disabling conditions.

#2 Improved Services for Those Young People with Chronic and Disabling Conditions

One of the most severe limitations of the Health Security Act as it currently stands is the provisions made for those children who are the most vulnerable in our society. In the name of promoting primary care we cannot leave such children so exposed. Neither, can we restrict habilitative services to those with acquired disabilities and illnesses. We need to explicitly include those with congenital health problems as well. We need to assure that a wide range of services are available to young people who have long-term care needs. Whether this is done through special provisions in the Health Security Act or through supplemental programs such as EPSDT is an issue of methodology. At a minimum the supplemental package should include:

- Long-term occupational therapy, speech-language pathology services, respiratory therapy, and physical therapy;
- Care coordination or case management services;
- Specialized nursing services, including in-home nursing care;
- Mental health services related to the treatment of chronic health problems;
- Custom-designed durable medical equipment, prosthetic, orthotic and adaptive devices, including assistive technology;
- Personal care services needed in conducting the activities of daily living;

- Respite care for family care takers; and
- Patient and family education and training related to a child's treatment needs.

#3 Confidential Services

While there is concern that adolescents wish to keep health issues secret, the reality is that most young people *do* tell their parents and seek their advice even for issues such as family planning services. On the other hand, for some adolescents there are certain health concerns and problems for which they will forego treatment rather than risk exposure; thus, access to confidential services is a sine qua non of adolescent health care. In truth, adolescents already believe that the world is watching them — that is why they spend so much time combing their hair. Another reality is that it is just those health concerns that place young people at greatest risk — including mental health, physical abuse, sexual and reproductive health, and substance abuse — for which confidentiality is *central* to seeking services. Failure to provide a mechanism for access to confidential services risks the health of both the individual and the community. Such failure manifests itself in increased costs and increased injury resulting from foregoing needed services.

#4 A Strong Public Health Infrastructure

A strong public health infrastructure is central to the successful implementation of the Health Security Act especially relating to continuous quality assurance as well as assurance of equity of services for vulnerable populations. For youth, Title V has historically been the central federal agency for oversight, training and research. While other agencies have

addressed categorical issues ranging from disabilities, teen pregnancy, STD surveillance and substance abuse, the Maternal and Child Health Bureau has explored systems of change through its demonstration projects, supported training in adolescent health through training grants and has facilitated the establishment of state-level capacity in adolescent health through developing a network of state adolescent health coordinators. I would encourage strengthening the functions represented by that public health authority.

In summary, the Health Security Act is a great step forward for young people as it is for all Americans. For youth, their special needs and opportunities require more complete consideration of the issues related to: confidentiality, co-payments, needs of youth with chronic and disabling conditions and a strong Maternal and Child Health Bureau. Thank you for giving me the opportunity to address you this morning.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

The American Association of University Women (AAUW) strongly supports the creation of a national health care system that ensures comprehensive and quality health care coverage for all Americans at an affordable cost. As an organization committed to improving the social, physical, and economic well-being of all individuals, AAUW believes that quality health care is a right, not a privilege.

Integral to achieving the goal of universal access to health care is availability of a wide range of service providers reaching as much of America's diverse population as possible. The creation of a health care continuum, from early childhood to old age, will require putting services where individuals and families can take advantage of them. AAUW believes that the schools must be key players in the provision of health services for children, and that school-based or school-linked clinics should be eligible for reimbursement by health care plans.

Services provided in a school-linked setting would improve both the health and educational performance of America's neediest children. It is obvious that students who suffer from depression or malnutrition, who become pregnant or have drug or alcohol problems cannot take full advantage of the educational programs available to them. And while coordination of services and health education would benefit all students, it has particular relevance to the lives and educational experiences of girls.

In 1992, the AAUW Educational Foundation released The AAUW Report: How Schools Shortchange Girls, highlighting a variety of issues that have an impact on the opportunities of girls to succeed in school and beyond. Among them were health needs currently given little attention and resources in most school systems. As this subcommittee reviews the President's and other alternative health care reform plans, AAUW urges that the needs of girls and young women, who represent 53 percent of the student population, be carefully considered and addressed.

Contraceptive Use and Sexually Transmitted Diseases (STDs)

The HIV infection rate for teenage girls is comparable to, and in some cases higher than, that for boys. While among adults, male AIDS cases are nine times more prevalent than female cases, the pattern of HIV infection among adolescents is very different. A 1989 study in the District of Columbia reports the HIV infection rate at 4.7 per 1000 for girls, almost three times the 1.7 rate for boys.

Comprehensive health education must be taught in all our nation's schools and must cover contraceptive use. STD counseling and contraceptives should be encouraged in school-based clinics to reverse this alarming trend.

Pregnancy

Research shows that nearly one-quarter of the school dropout rate is attributable to teen pregnancy. Nearly half of the girls who drop out do so because they are pregnant or have one or more children, making pregnancy a pressing educational issue, for young women and for the welfare of future generations. A mother's educational level is universally known to be one of the best indicators of her child's academic success. Children raised by mothers who never complete high school experience higher rates of academic failure and behavioral problems. Over half of all mothers now on welfare bore their first child as a teenager. Pregnancy prevention must be an integral part of health education programs and health services.

Health services for students who are already pregnant are also critical. Fully one-quarter of pregnant mothers receive no medical care of any sort during the crucial first trimester of pregnancy. About 20 percent of children with disabilities would not have that disability had their mother had one physical exam during this period (Phi Delta Kappan 9/91). The United States has a higher infant mortality rate than Japan, Canada, and most European countries, according to a recent report; the rate is particularly high for African American infants.

Every dollar spent on prenatal care saves \$3.38 in the cost of caring for low birth weight babies. This is just one example of how putting health services in the schools can reach a needy

segment of the population and make better use of scarce funding.

Eating Disorders

Food binging and chronic dieting are, sadly, a regular feature of the high school, junior high, and even upper elementary school landscape. A 1989 National Adolescent Health Survey of 10,000 public school students found that 61 percent of girls reported having dieted in the past year, compared with 28 percent of boys. Half of those who dieted had fasted as a means of weight loss. Girls are also more likely than boys to report vomiting to control their weight and to abuse over-the-counter appetite suppressants. Severe cases of bulimia and anorexia nervosa can cause death.

Diet counseling, nutrition and exercise information, and health education programs that consciously promote positive self-image can help combat forces in society that wreak havoc on girls' self-esteem.

Depression and Suicide

Shortchanging Girls, Shortchanging America, a study published by AAUW in 1991, found that girls' self-esteem drops dramatically as they move through adolescence. Other research shows that females have higher rates of depression than males, during both adolescence and adulthood. Severely depressed girls have been

shown to have higher rates of substance abuse than similarly depressed boys. Significant gender differences were also found in school performance measures among the most depressed students: grade point averages were lower for girls, and 40 percent more girls failed a grade than boys. Adolescent girls are four to five times more likely than boys to attempt suicide (although boys, who choose more lethal methods, are more likely to be successful in their attempts).

RECOMMENDATIONS

Suggested Health Services: AAUW respects the importance of flexibility for grant recipients in deciding what services to offer and with whom to coordinate provision of services. However, we are also painfully aware that unless specified, the needs of females are often not met by school systems, in or out of the classroom. We urge greater specificity in listing the kinds of services to be provided by these initiatives. Services must include: pregnancy-related services, contraception, maternal and child health, lab and testing services, and counseling and information on eating disorders, nutrition, substance abuse, sexually transmitted diseases (including AIDS), and depression and suicide.

Comprehensive Health Education: AAUW advocates the promotion of comprehensive K-12 age-appropriate health education programs. Curricula should recognize and address the different needs of

female and male students and actively seek to improve the self-image and self-esteem of students.

Referrals: School-based clinics should be given flexibility in the kinds of services they provide and be able to refer students to other easily-accessible health service providers where necessary.

Enabling Services: AAUW commends the Clinton Administration's inclusion of "enabling services," which increase the capacity of individuals to utilize the services in the comprehensive benefits package. Transportation is a key access issue for many young women and girls. We also urge that dependent care assistance, which was not listed in the Clinton bill, be specified in any health care reform plan.

Suggested Partners: AAUW urges inclusion of a list, in the section describing contents of the grant application, of suggested agencies and service providers that should be considered for partnership or advisory status. Certain segments of America's population seem continually at risk of being forgotten or excluded, unless attention is called to them early and often. A list of suggested partners should include juvenile justice workers, social workers, legal services offices, WIC and Welfare administrators, and service providers for migrant children, recent immigrants, and parents and children with limited English proficiency.

CONCLUSION

Throughout the health care reform process, AAUW will be working to ensure that women's health needs are recognized and met. AAUW believes that the coordination of health, social, and educational services in a school-based or school-linked setting, if sensitive to the needs of all students, is a critical "jumping-off point" for a lifelong system of comprehensive health services. We urge this subcommittee to help build successful coordinated service programs by ensuring that the needs of all students are recognized by those community leaders who will be planning and implementing this crucial aspect of health care reform.

STATEMENT
of
THE AMERICAN FERTILITY SOCIETY

The American Fertility Society (AFS), an organization of more than 11,400 physicians and scientists specializing in reproductive medicine, is pleased to have this opportunity to comment on HR 3600, the Health Security Act. The AFS believes that meaningful health revision requires an emphasis on coverage for health maintenance and disease prevention as well as for the diagnosis and treatment of illness, including infertility.

An essential part of significant health care reform is coverage for reproductive health services. These services include prevention of unintended pregnancy, sexually transmitted disease, infertility, gynecologic cancer, osteoporosis and cardiovascular disease. The services also include safe and effective treatment for infertility and other reproductive disorders.

The AFS applauds the President's decision to include coverage of reproductive health services in the Health Security Act. Family planning services are low-cost and cost-effective, and coverage should include counseling, contraception and sexually transmitted disease screening and treatment. We believe health reform must cover other essential preventive services like mammography and pap smears, the benefits of which have been well documented. The health plan for this country should provide coverage for pregnancy diagnosis, prenatal care, nutrition counseling, prescription drugs, labor and delivery and postpartum evaluation and services. We emphatically assert that these services should also include the diagnosis and treatment of infertility.

Infertility is a disease which affects the human reproductive system and can lead to an inability to have children. It affects one in every 12 couples. It is defined as a disease in which there is abnormal function of the reproductive system of either the male, female or both partners which requires indicated, not elective, treatment. The disease can be

traced to medical problems in the female roughly a third of the time, medical problems in the male a third of the time, and a combination in both partners for the remaining third. We believe that any benefits package should include medically necessary and medically appropriate therapy for these infertile couples.

Left untreated, some infertility conditions can lead to serious health risks which will be more costly to treat down the road. For example, pelvic inflammatory disease can lead to scarring of the fallopian tubes, which can lead to the life-threatening condition of ectopic pregnancy.

Most infertility -- 85 to 90 percent -- is treated with conventional medical and surgical therapy, from drug treatment to surgical repair of reproductive tract structures in both men and women. The majority of infertile couples require relatively low-cost conventional methods of treatment. Other treatment options include assisted reproductive technologies, standard clinical procedures which require the use of a laboratory to process human sperm and eggs. In vitro fertilization (IVF) is the most well-known of these techniques, although fewer than five percent of infertile couples who seek therapy are actually treated with IVF and other assisted reproductive technologies. The national health plan should provide coverage for both the conventional and assisted reproductive technologies.

In a letter from Dr. Judith Feder of the Department of Health and Human Services (attached), she states that "appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language...The plan covers all services that a clinician has determined to be medically

necessary or appropriate unless specifically excluded. The only infertility service excluded from the plan in vitro fertilization." Although this letter is reassuring that conventional infertility services are covered in the Clinton health care plan, they are not specifically mentioned and we would like to see the word "infertility" included in the bill.

The AFS is grateful that the diagnosis and treatment of infertility are now covered under the proposed Health Security Act. However, we are very concerned about the specific exclusion of in vitro fertilization services. We strongly believe that this exclusion should not be in the statutory language for the following reasons:

- ◆ Exclusion will displace the medical decision-making process for medically necessary and appropriate procedures from physicians, patients, and the informed consent process.
- ◆ Exclusion will cancel present IVF coverage provided to individuals in the states of Arkansas, Hawaii, Illinois, Massachusetts, Maryland and Rhode Island, and other individuals who have coverage for this benefit. Practitioners estimate that 30 to 40 percent of IVF cycles are partially or completely covered at this time.
- ◆ Exclusion will deny access and availability to those in need, and will shift infertility management back to less effective and frequently more invasive and more costly procedures.
- ◆ Coverage would add minimal costs to the benefits package. For example, mandated fertility coverage in Massachusetts accounts for four-tenths of one percent of the cost of the family package. In vitro fertilization services account for one-tenth of one percent of the package. There would be additional cost savings as a result of

the reduction in the number of less-effective infertility services presently performed because they are covered by insurance.

In sum, providing benefits for reproductive health services is a vital part of any meaningful health system reform. Disease prevention -- via mammography and other screening -- clearly saves both lives and dollars. Family planning services are fundamental to preventive health care for women, since the ability to control the timing and spacing of pregnancy directly relates to the health and well-being of women. Moreover, the desire to parent is among the most fundamental desires of the human race, and is essential to the sustenance of society and the human spirit. Coverage for pregnancy-related services - including infertility diagnosis, treatment and in vitro fertilization will be an integral part of any health reforms enacted.

AFS is eager to help the Subcommittee on Health and the Environment determine what will be appropriate revision of the health care system. We applaud your involvement in this matter of great importance, and we thank you for the opportunity to comment.

Robert D. Visscher, M.D.
Executive Director
American Fertility Society
1209 Montgomery Highway
Birmingham, AL 35316

(205)978-5000

AMERICAN HEART ASSOCIATION

Statement

The American Heart Association submits the following testimony in response to H.R. 3600, the Health Security Act of 1993, in light of the treatment needs of women with cardiovascular diseases. The AHA is this nation's largest voluntary health organization dedicated to the reduction of disability and death from cardiovascular diseases, including heart attack and stroke. Annually, AHA's 56 affiliates nationwide coordinate the activities of about 3.7 million volunteers in carrying out this mission. Coronary heart diseases and stroke remain the single largest cause of death in the United States, and the number 1 and 3 killers of women, respectively.

Despite progress, cardiovascular diseases remain the No. 1 killers of women in the United States. Almost 46 percent of all female deaths in the United States are from cardiovascular diseases. More than one in five Americans have some form of cardiovascular disease. In America all cardiovascular diseases combined claim more than 479,000 women's lives each year -- more than double that of all forms of cancer combined (about 242,000.) Coronary heart disease alone kills more than five times as many women as breast cancer.

Until recently, cardiovascular diseases in women have not been recognized as a serious health problem, particularly by women themselves. Of the over 478,000 deaths from heart attack each year, 48.4 percent occur in women. Women, however, develop heart disease later in life than men. Since 1984 cardiovascular disease deaths of women have exceeded those of men.

At any age, heart attack in women is a more deadly disease, but older women are twice as likely as men to die during the first few weeks following a heart attack. Thirty-nine

percent of women who have heart attacks die within a year, compared with 31 percent of men. In the four years after an initial heart attack, a second heart attack occurs in 20 percent of women, compared to 16 percent of men.

In light of the deadly and disabling impact of cardiovascular disease on women, the AHA has focused its efforts on working with Congress and the Administration to insure that health care reform includes the necessary elements for research, prevention and effective treatment of cardiovascular diseases. The American Heart Association appreciates the Clinton Administration's commitment to health care reform as embodied in the Health Security Act. No previous administration has demonstrated more commitment to the health care reform needs of this country.

The position of the American Heart Association on health care reform has been guided by our five principles on Access to Health Care, which the Association feels are critical to any health care reform package. The AHA principles are:

1. All residents of the U.S. should have access to quality medical care.
2. Universal coverage for basic medical care should be available.
3. Coverage for preventive care must be part of any access proposal.
4. Funds must be allocated for biomedical research, research training and clinical training.

5. The AHA should participate in the development of guidelines for appropriate patient care and should support research into methods to measure quality, outcomes and cost-effectiveness.

The American Heart Association reserves endorsement of any one particular health care reform proposal. However, the Association recognizes that many of its concerns are addressed in the Health Security Act of 1993.

In particular, the American Heart Association commends the Clinton Administration for emphasizing access to care in the Health Security Act, especially that, regardless of preexisting conditions, all U.S. residents must have access to quality medical care, including appropriate medications and prevention programs. In addition, the AHA applauds the Clinton Administration's commitment to universal coverage of basic medical care, including cardiovascular care.

The AHA is pleased to find the strong emphasis in the Health Security Act on effective utilization of resources, and we appreciate the support for the development of practice guidelines by professional groups with appropriate expertise. We are also pleased to see that Title V of the Act, Quality and Consumer Protection, would focus government resources on developing knowledge of treatment outcomes generated by health services research to determine not only clinical effectiveness, but also cost effectiveness.

The AHA is also pleased to see that the Health Security Act contains specific provisions to support health services research.

Preventive Benefits

The data on the incidence of death and disability resulting from cardiovascular disease indicates the value and cost-effectiveness of preventive efforts. Cardiovascular diseases are the leading cause of death in women in the United States and cardiovascular disease deaths are 63 percent higher for females than all female cancer, accident, and diabetes deaths combined. Each year more than 235,000 women die of a heart attack, and breast cancer claims the lives of about 43,300 females.

From 1979 to 1991, in white women, there was a 26 percent decline in age-adjusted death rates from diseases of the heart and a 36 percent decline in death rates from stroke, and among black women, a 17 percent and 33 percent decline, respectively. Despite these substantial declines in death rates, heart attack and stroke still rank first and third, respectively, as the causes of death in all women, with substantially higher rates among black women. With each decade of life, the rate of deaths from heart disease increases from 3- to 4-fold and by the age of 75 years the death rate in white women is over 1,800 and black women over 2,200 per 100,000.

Since 1984, cardiovascular disease caused a greater proportion of deaths in women than men, that is, 51.8 percent in women and 48.2 percent in men. Death rates from cardiovascular disease, however, are only the tip of the iceberg; one in seven women between 45-64 years of age has some form of heart disease or stroke. After age 65 the ratio increases to 1 in 3 women. The number of women with cardiovascular disease continues to grow each year. Physicians should be aware that the perceived risk and fear of cancer seems much greater in women than their perceived risk of heart disease or

stroke. Before women can take action regarding their cardiovascular risk, they must understand their risk of death or disability resulting from these diseases.

Another indication of the impact a disease has on society is the costs incurred. The costs in 1994 of cardiovascular disease is estimated to be \$128 billion. This includes medical costs and the lost productivity resulting from disability. It is estimated that women consume over half, about 58 percent (\$74.2 billion), of the yearly health care costs related to cardiovascular diseases, although they have about one-half the death rate of cardiovascular disease as men.

Other cardiovascular diseases are also prevalent in women. More than 86,000 women each year die of stroke. This comprises 61 percent of fatalities from stroke. Much less prevalent are cases of rheumatic heart disease, an inflammatory disease that permanently damages the heart and its valves. Even in this disease, however, there is a higher death rate in women than in men (1.7-1.8 death per 100,000 for women, compared to 1.1-1.2 per 100,000 for men). Only congenital heart disease is less deadly in women than in men.

All told, heart and blood vessel diseases combined claim over 479,000 women's lives each year, more than all forms of cancer combined.

As a result of research, we are able to identify risk factors for cardiovascular disease, which can then lead to cost-effective prevention. Major atherosclerotic disease risk factors operate in women as well as in men. High blood pressure is a predictor of coronary artery disease in both women and men.

Smoking is a significant risk factor for heart attack in women. There are 23 million women smokers in the United States. They are 2 to 4 times more likely to suffer a heart attack than their non-smoking counterparts. In previous years we had seen a decline in the number of women smoking, but from 1990 to 1991, there was a 2.2 percent increase in smoking among women. The population group, moreover, in which smoking is on the increase is young women in their teens and twenties. The reasons for this are many and not all related to medical issues. Nevertheless, this is an area that requires further study and intervention.

The AHA is pleased to see that, under the Health Security Act, preventive care is a significant part of the basic benefit package and that resources would be targeted to prevention of heart disease. The Clinton plan emphasizes preventive care, especially cholesterol screening.

We are concerned, however, about the definition of risk assessment in the plan. Although smoking cessation classes are specified under health education, and nutrition counseling would be offered under clinician visit target health advice, we are unclear whether clinician visits include smoking cessation counseling, stress reduction and high blood pressure advice. It is also unclear how these services are going to be determined.

The AHA has developed a basic preventive benefit package, which is attached, and supports inclusion of its recommended benefits in the health plan.

Biomedical Research

Research and prevention programs must be key components of health care reform because they save women's lives and money. Support for basic biomedical research funding is critical for innovative approaches to the diagnosis, treatment and prevention against cardiovascular diseases in women, including heart attack and stroke.

The AHA believes that funding for biomedical research, research training, and training of cardiovascular specialists must be included in health care reform. This includes the following:

- o support for basic and clinical research at a level that allows reasonable growth
- o support for research training at a level that eliminates current downward trends in research manpower; and
- o resources adequate to supply needed equipment and other types of scientific research infrastructure.

Since 1948 the AHA and the National Heart Lung and Blood Institute have been active partners in the battle against cardiovascular diseases, including heart attack and stroke. Throughout this 43 year partnership the research, training, education, and community service programs of both the AHA and the NIH have had a significant impact. From 1981 to 1991 the age-adjusted death rate from heart attack fell 32.4 percent and that from stroke fell 30.5 percent. This trend is largely attributable to advances in medical

treatment, healthier lifestyles, and control of risk factors such as elevated blood cholesterol high blood pressure, and smoking.

There is still a long way to go. In the United States someone dies from cardiovascular diseases every 34 seconds. More than one in five Americans suffer some form of these diseases.

In 1990 total cardiovascular disease accounted for 4.740 million years of potential life lost before age 75, followed by cancer and accidents. There will be even more cardiovascular disability because many people who have had effective treatment for coronary artery disease and prevention of arteriosclerosis at age 40 to 60 will develop cardiovascular diseases later in life.

The estimated cost of cardiovascular diseases in 1994 will be \$128.0 billion in medical expenses and lost productivity. Costs for patients with cardiovascular diseases grow because we are treating disease with expensive technology, not preventing it.

Our ability to control cardiovascular diseases depends on the level of quality of overall support of basic and clinical research and prevention efforts. Throughout its history, the AHA has emphasized prevention, investing heavily in research. Basic research is the starting point of all medical advances. Biomedical research remains the number one priority of the AHA. Since 1949, the AHA has invested almost \$1.2 billion in research and has developed education and community programs to promote health and to prevent and reduce the risk of heart attack and stroke. In 1992-1993 the AHA, including its 56 affiliates nationwide, contributed almost \$93 million to research. The size of this financial commitment makes the AHA second only to the federally sponsored National Heart,

Lung and Blood Institute as a principle supporter of cardiovascular research. AHA-funded research has yielded many important discoveries, including CPR, life-extending drugs, bypass surgery, pacemakers and other surgical techniques to repair defects.

The AHA believes that basic biomedical research drives all other health research. We were very happy to hear Dr. Shalala, Dr. Lee, Mr. Ira Magaziner and other Administration health policy staff affirm the Administration's commitment to increased biomedical research funding.

We continue to be concerned, however, that the plan lacks any vehicle that would assure necessary increases in funding for basic biomedical research, apart from the appropriations process, where increases would be subject to spending caps under the budget agreement.

Although the Clinton plan emphasizes preventive and health services research, there is concern that failure to support basic biomedical research will slow innovation and ultimately limit cost effective treatments.

We believe that the allocation of funds for biomedical research is pivotal to any health care reform plan. In light of the data on the prevalence of cardiovascular disease in women, a substantial increase in support for biomedical research is critical for further advances in the diagnosis, treatment and prevention of cardiovascular disease in women.

AMERICAN PAIN SOCIETY

AMERICAN ACADEMY OF PAIN MEDICINE

AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

The American Pain Society, the American Academy of Pain Medicine and the American Association for the Study of Headache strongly support universal health coverage for all Americans. At the same time, these organizations urge policymakers to recognize that coverage and benefits must also guarantee access to appropriate care. Any Federal legislation which relies on managed competition or managed care, must address the special needs of special patients - patients whose illnesses fall outside the realm of usual and customary care.

Certain illnesses, and complex or advanced cases of many others, are not effectively treated in tightly controlled systems emphasizing primary care services. These conditions are frequently misdiagnosed - or undiagnosed. Patients are frequently mistreated - or untreated. "Gatekeepers" impede rather than facilitate appropriate early intervention. These cases stand out. They are not routine. When they are widespread, chronic, and high cost, they require special consideration in any new Federal legislation.

Certain of these illnesses, including intractable pain are also literally intolerable to the patient. They impact so dramatically on the quality of an individual's life and the ability to function as to prompt desperate searches for relief in and out of a patient's primary health network, and in and out of proven treatment modalities.

Reform must deal fairly and effectively with these special needs of special patients. The undersigned strongly urge inclusion of the following protections for patients afflicted with intractable pain, including cancer pain and acute pain, and similar conditions:

- I. EVERY CONSUMER SHOULD HAVE A FEE-FOR-SERVICE AND POINT OF SERVICE OPTION AT THE TIME OF HEALTH PLAN ENROLLMENT. THIS OPTION SHOULD BE REAL - NOT SUBJECT TO WAIVER BY STATES, ALLIANCES OR PLANS, OR SUBJECT TO INORDINATELY HIGH COST SHARING REQUIREMENTS.
- II. QUALIFIED HEALTH PLANS MUST GUARANTEE PATIENT ACCESS TO, AND ACTUALLY DELIVER APPROPRIATE SPECIALTY CARE FOR INTRACTABLE PAIN AND SIMILAR ILLNESSES.
- III. GATEKEEPERS EMPLOYED IN QUALIFIED HEALTH PLANS MUST:
 - Be properly trained for the clinical judgements they are asked to make, e.g. where prior authorization is required for specialty referral or treatment;
 - Not have financial incentives to undertreat or under-refer;
 - Perform a contemporaneous evaluation of the patient before overriding another physician's clinical judgement; and
 - Be accountable for the clinical judgements made in their capacity as gatekeepers.

- IV. NETWORK PLANS MUST BE REQUIRED TO DEMONSTRATE CAPACITY TO EFFECTIVELY TREAT INTRACTABLE PAIN AND SIMILAR ILLNESSES WITHIN THEIR OWN NETWORK, OR THROUGH REFERRAL ARRANGEMENTS OUTSIDE THE NETWORK, AND PROVIDE OUTCOME DATA TO PROVE EFFECTIVENESS.
- V. REFERRAL ARRANGEMENTS MUST BE TARGETED TO PROPERLY TRAINED PRACTITIONERS, ACADEMIC CENTERS, AND "CENTERS OF EXCELLENCE" WHICH SPECIALIZE IN THE TREATMENT OF INTRACTABLE PAIN AND SIMILAR ILLNESSES.
- VI. FEE SCHEDULES MUST RECOGNIZE THE SCOPE AND INTENSITY OF SERVICES DELIVERED BY SPECIALTY PRACTITIONERS AND MULTI-DISCIPLINARY TEAMS TO PATIENTS WHO HAVE FAILED TO RESPOND TO CUSTOMARY AND USUAL CARE. UNTIL APPROPRIATE SCHEDULES ARE DEVELOPED, BALANCE BILLING BY SPECIALTY PRACTITIONERS, ACADEMIC CENTERS AND CENTERS OF EXCELLENCE SHOULD BE PERMITTED.

HUBERT ROSOMOFF, M.D.
President, American Pain Society

PETER WILSON, M.B.B.S., Ph.D.
President, American Academy of Pain Medicine

SEYMOUR SOLOMON, M.D.
President, American Association for the Study of Headache

Adopted: October 1993

AMERICAN PAIN SOCIETY
AMERICAN ACADEMY OF PAIN MEDICINE
AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

THE FACTS ON INTRACTABLE PAIN

- Pain is a major public health problem in the United States
- **50 million** Americans are partially or totally disabled by pain
- **45%** of all Americans seek care for persistent pain at some point in their lives
- **Headache and low back pain** are the most prevalent forms of intractable pain
- Pain accompanies a wide range of other clinical conditions, including:
 - cancer
 - diabetes
 - arthritis
- **22%** of work-related injuries involve back pain
- **150 million** workdays are lost annually to head pain alone
- Children lose **1 million** school days annually due to pain
- Intractable pain is frequently **untreated or mistreated**
- Mismanagement of pain has tragic and costly consequences:
 - addiction
 - disability
 - depression
 - over-utilization of diagnostic services and procedures
 - hospitalizations and surgery
- Pain can be effectively treated:
 - with early intervention
 - by appropriately trained specialists
 - frequently in ambulatory settings
 - at reasonable cost

Testimony of George Dunbar
President and Chief Executive Officer
Metra Biosystems, Inc.

Thank you for the opportunity to submit testimony to the Subcommittee. My name is George Dunbar, and I am President and CEO of Metra Biosystems, Inc., a company specializing in new biomedical products for the detection and management of bone and joint diseases. Metra is currently awaiting FDA clearance of an exciting new product, a urine test to detect bone loss. This new test will assist physicians in the early detection and management of bone loss which leads to osteoporosis, and is designed to be cost-effective utilizing existing laboratory instrumentation.

The purpose of my testimony is to support the inclusion of yearly osteoporosis screening for peri-menopausal and post-menopausal women as a covered preventive service under healthcare reform. The relatively small investment entailed with yearly screening of the appropriate patient groups, will yield substantial and long-term savings in the management of osteoporosis among the elderly. To encourage appropriate utilization of these important services by all socioeconomic levels, a very modest or no copayment should be charged, as with other important preventive measures already identified in the President's healthcare bill.

I have two important points I would like to make regarding osteoporosis. First, osteoporosis is a preventable, but not a treatable or reversible condition. Inexpensive drugs exist to stabilize bone loss once it is detected, but there are no drugs to generate new bone. Very simply, once one loses bone there is no opportunity to get it back. Second, urine tests exist today to identify those who may be at risk of osteoporosis before they

have lost large amounts of bone. These inexpensive urine tests would also monitor the effectiveness of therapy undertaken to prevent further bone loss.

Osteoporosis is defined as a decrease in the absolute amount of bone mass which leads to fracture after minimal trauma. Metabolically, it is the end result from an imbalance between bone formation and resorption (or bone loss), with an overall net increase in bone resorption over time. Such a pattern of bone loss is consistent with loss of bone strength sufficient to place the patient at risk of fracture. Osteoporotic fractures generally occur at the vertebrae, hips and wrists, and often result in spinal deformity, pain and loss of height.

Bone loss, which leads to osteoporosis, is an essentially symptomless condition, a silent disease. The outwardly visible signs such as fractures, spinal deformity, and loss of height do not manifest themselves until bone loss is extensive. Thus, at risk patients are not identified until it is essentially too late to manage the condition. Today, less than 3 percent of postmenopausal women are being treated for the prevention of osteoporosis.

Osteoporosis affects 25 million Americans, predominantly women. In the United States, 1.5 million fractures are attributed to osteoporosis each year. Twelve to 20 percent of osteoporosis fractures are fatal. As I mentioned above, current science allows for the prevention, but not the reversal of osteoporosis. Approved drugs used today to halt or prevent bone loss include estrogen and calcitonin. Of these, estrogen, or

hormone replacement therapy, is the most common treatment in the United States. As with other antiresorptive drugs, estrogen's effectiveness varies directly with the level of bone turnover, being most effective when turnover rates are high and least effective when they are low. This underscores the importance of early detection.

The well-documented progression of bone mass changes associated with growth and aging indicate the ideal time to detect people at risk of developing osteoporosis. We all achieve our peak bone mass between ages 35-45. For women, the onset of menopause is associated with the most rapid rate of bone loss. Thus, if women were monitored for changes in the rate of bone turnover in the peri-menopausal years, roughly between ages 45-55, bone loss could be detected early and further loss prevented with appropriate therapy.

Because no simple, inexpensive osteoporosis screening techniques are widely used, today most cases of osteoporosis are diagnosed after the fact and when the patient is in their late sixties or older. At this stage years of bone loss have already occurred. Preventive efforts at this stage yield little or no results, since most of the bone loss the patient will experience has already taken place.

Two technologies assist the physician in detecting bone loss by providing very different types of information - bone densitometry and biochemical tests for bone loss. Bone densitometry, an X-ray technology, accurately measures the bone density, or bone mineral content. These X-rays can usefully

establish a baseline level of bone mass against which future measurements may be compared.

Technology also exists today which can detect bone loss and also monitor the effectiveness of preventive therapy. The metabolic processes of bone turnover result in distinct by-products, or biochemical markers found in blood and urine and are measured with existing and currently available laboratory equipment. We expect that this test will be priced to the patient at a level comparable to other routine blood or urine tests. The test result can be compared to a normal range in the same way that a patient's temperature might be compared to the normal 98.6 degrees. Any reading above the normal range means that bone loss is elevated. This information allows the physician and patient to assess the potential need for preventive measures, any additional testing to determine the basis for the bone loss, or simply watchful waiting.

These tests are available throughout Asia and Europe, but are restricted to research purposes today in the United States. In August of 1993 the FDA issued guidelines to drug manufacturers developing anti-osteoporosis drugs urging them to use biochemical markers of bone turnover in their clinical activities to help assess the efficacy of drugs being developed. We are hopeful that FDA clearance of our technology for use with patients will come later this year, before action on healthcare reform is completed.

For the patient, our technology provides a direct and immediate detection of bone loss which will help identify

candidates at risk of osteoporosis before further bone loss occurs. For the physician, the technology will make currently available therapy more effective by allowing early diagnosis and allow for effective monitoring of preventive treatment and compliance to treatment regimens. This last point is important because of the relatively high level of non-compliance when patients are asked to take drugs where there are no visible or physical symptoms of the disease progression: 15% never fill the prescription and 39% discontinue therapy within the first year.

Today's technologies for osteoporosis management include antiresorptive drugs to prevent or halt further bone loss, biochemical tests of bone turnover to detect patients at risk of osteoporosis and monitor treatment, and X-ray densitometry to establish baseline levels of bone mass and document changes in bone mass over time. These techniques combine to offer an effective means to detect and prevent osteoporosis for the entire at-risk population.

Additional research related to osteoporosis is not needed for us to begin early detection and treatment regimens for those at risk. The National Osteoporosis Foundation estimates that the direct and indirect costs of osteoporosis-related fractures in this country to be over \$10 billion annually. The costs of hospitalization, surgery, and potential rehabilitation for a hip fracture (exclusive of physician fees) are estimated at \$26,000 per case.

With early detection, patients experiencing bone loss can be identified, and preventive measures taken to substantially reduce the incidence of fracture and the associated social and economic costs. Osteoporosis screening is the essential first step to identify those patients at risk. I urge the Subcommittee to include osteoporosis screening as a covered preventive service in the standard benefit package under healthcare reform.

STATEMENT OF NATIONAL OSTEOPOROSIS FOUNDATION

Mr. Chairman, my name is Sandra Raymond and I am the founding Executive Director of the National Osteoporosis Foundation. As you know, osteoporosis is a silent, bone-thinning disease which affects 25 million Americans. Eighty percent of those affected by osteoporosis are women, which is why osteoporosis stands as one of the three leading diseases of women. One in two women and one in five men will develop fractures due to osteoporosis, typically fractures of the hip and spine. It is a little known fact that a woman's risk of developing a hip fracture is equal to the combined risk of developing breast, uterine, and ovarian cancer.

In the 1990's, osteoporosis will result in 2.5 million hip and 5 million vertebral fractures causing pain, disability, deformity, loss of independence and death. In fact, 375,000 individuals will die due to complications resulting from these fractures. With hip fracture, the most serious consequence of osteoporosis, at least half of those able to walk before sustaining a hip fracture do not walk independently afterward. Their ability to care for themselves is compromised and their quality of life is reduced. Half of all hip fracture victims experience social deterioration and one-third may be totally dependent. For many women and older men, hip fracture is often the event that precipitates institutionalization.

Vertebral fractures are also disabling since compression of spinal bones cause not only deformity, but also the realignment of the body causing compression of the abdominal organs leading to difficulties in eating and swallowing and an awkward gait which may precipitate a fall leading to other fractures and pain.

Without interventions, the problem of osteoporosis will worsen as the population ages. In 1992, the acute care costs of one hip fracture was \$40,000 and this figure does not include the long-term care costs associated with this catastrophe. The direct and indirect costs of osteoporosis in the U.S. in 1992 were \$10 billion. However, if we don't stop it now, these costs are expected to rise to \$60 billion by the year 2000 and \$200 billion by the year 2040.

Recently, the University of Southern California's Gerontology Center ranked osteoporosis, along with Alzheimer's disease, as potential federal "budget busters." If osteoporosis is not addressed through comprehensive programs of medical research and preventive health strategies, the costs of osteoporosis will swamp any efforts to contain rising health care costs.

Osteoporosis is a model for health care cost containment. The health care reform movement can begin to stem the tide of this national tragedy. While we cannot yet replace bone once it is lost, osteoporosis is an essentially preventable and treatable disease. We presently do have the means to greatly reduce the human and economic toll of osteoporosis.

The basic benefits package of a national health plan which strives to prevent disease before its onset must address osteoporosis.

We now have safe, effective, reliable, and accurate tests to measure bone mass. These non-invasive tests can detect low bone mass and accurately predict the risk of future fractures. These tests are even more predictive of a catastrophic event, such as hip fracture, than the blood pressure and cholesterol tests used to ascertain the risk of cardiovascular disease and stroke. A protocol for reimbursement is as follows:

Bone mass measurement tests are recommended to assist physicians in identifying those postmenopausal women and others at risk for osteoporosis in whom discovery of susceptibility is needed to decide upon treatment, and to monitor the effectiveness of that treatment. A single test is performed to define risk and a follow-up test is undertaken after an appropriate interval, e.g., 2 - 5 years, or as medically necessary, to monitor the efficacy of treatment.

A basic benefits package which includes early detection, treatment and management of patients with osteoporosis and osteoporotic fractures must include reimbursement of bone mass measurement tests, and coverage for emerging biochemical tests to determine high-risk populations, physician visits, medications, inpatient and outpatient rehabilitation services, and long-term care.

And, with an expanded federal medical research effort, osteoporosis will be brought under control. The present biomedical research program on osteoporosis is woefully inadequate. The lead Institute of the National Institutes of Health (NIH), the National Institute for Arthritis and Musculoskeletal and Skin Diseases (NIAMS), which has the responsibility for osteoporosis research, has never achieved parity with the other Institutes of Health. Outstanding peer-reviewed research grants on osteoporosis are not being funded due to the extremely low payline of this Institute.

The NIAMS payline for osteoporosis grants is around the 12 percent level whereas the average payline for NIH is 25 to 26 percent. With a reasonable biomedical research effort, experts in the field agree that osteoporosis can be brought under control in the next decade. While the NIH Revitalization Act of 1993 authorized \$40 million in new funds for osteoporosis research, no new funds for this purpose were appropriated by Congress in FY 1994. Current federal spending on osteoporosis research is little more than \$1 per person affected by the disease.

In closing, a comprehensive national strategy to address osteoporosis, which includes a coordinated program of research, health policies, insured coverage for osteoporosis services and a program of public education to alert the American people to the consequences of this silent, devastating disease must be established in FY 1994.

Thank you.

Testimony Submitted by RESOLVE
for Hearings on Women's Health Care
Subcommittee on Health and the Environment
Wednesday, January 26, 1994

Mr. Chairman and Members of the Subcommittee, RESOLVE is pleased to submit this testimony on behalf of its 25,000 members and the 5.3 million Americans who suffer from the disease of infertility. We are very supportive of your efforts to reform this nation's health care system which currently discriminates against the infertile by frequently denying them coverage for medically appropriate treatment. I will use this opportunity to provide the Subcommittee with some important information about infertility and to urge the Subcommittee to include comprehensive infertility diagnosis and treatment in any benefit package enacted as part of national health care reform.

RESOLVE is a national, nonprofit organization established in 1974 to provide support, education and advocacy for infertile couples. Today we have 56 chapters across the country. Our national HELP LINE receives hundreds of calls annually from people needing information about various treatments or clinics and those seeking help with the emotional trauma of infertility. Our local chapters offer support groups run by trained therapists, educational seminars on infertility developments and treatments, information on adoption and child free living, and advocacy efforts at the state and federal levels.

RESOLVE's membership is very pleased that the Clinton Administration has included most infertility treatment in the benefit package of the Health Security Act (HR 3600). I have attached a letter from Dr. Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, which specifies that "...appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language." We are dismayed, however, that Dr.

Feder goes on to state, "The only infertility service excluded from plan coverage is in vitro fertilization." RESOLVE strongly believes that totally excluding in vitro fertilization (IVF) from coverage is medically and fiscally irresponsible since it is the most medically appropriate and cost effective treatment for some forms of infertility. I will return to the subject of in vitro fertilization later in this testimony.

First I would like to give you some important facts about infertility, a disease of the reproductive system that is greatly misunderstood by the general public because, unless faced with this condition, most people have given it little thought. Media stories have helped to create misperceptions by attempting to sensationalize a real and tragic problem. Numerous stories printed or aired recently have been poorly researched and contained erroneous information. Following is factual information that I hope will enhance your understanding of infertility which is a serious medical condition that exacts an enormous toll on those who suffer from it, their families and friends, and society as a whole.

Definition and Scope of Infertility

- *Infertility is a disease or malfunction of the male or female reproductive system.* A specific medical problem can be identified in eighty percent of all cases of infertility. The other twenty percent includes cases in which a combination of problems are present or the cause of the infertility cannot be isolated. The reproductive system is one of the major systems in the human body. Diagnosis and treatment of reproductive problems should be covered by health care insurance just as problems with the digestive system, respiratory system or muscular system are covered. Infertility is **not** a life style choice; medical treatment for this disease is **not** elective.

- *Infertility affects 5.3 million Americans, or approximately 10 percent of the reproductive age population.* This means that one out of every six couples in this country will face an infertility problem of one kind or another.

- Men and women suffer equally from infertility. Male factor infertility accounts for fifty percent of identifiable problems (low sperm count, poor sperm motility, hormonal imbalances, deformities in the reproductive organs, and other abnormal functioning). Female factor also accounts for fifty percent of identifiable difficulties (ovulation problems, fallopian tube damage or disease, hormonal imbalances, ovarian tumors or cysts and other abnormalities). These conditions can be diagnosed and medically appropriate treatments, ranging from simple drug therapy to corrective surgery or in vitro fertilization, can be used with successful outcomes, that is, pregnancy, possible about half the time. According to a federally funded study published in July 1993*, more than 98 percent of people with infertility can be treated by conventional drug and medical/surgical procedures; only 1.2 percent use IVF.

- Infertility affects a very broad range of people. It knows no boundaries of race or socioeconomic status. For example, the children of mothers who took DES (diethylstilbestrol) have an increased incidence of infertility. Adult males who contract mumps may become sterile. Some asthma sufferers take a drug that can cause infertility. Environmental pollutants can adversely affect reproduction. No group or individual is immune from the possibility of not being able to create a biological family on their own.

Rationale for Including In Vitro Fertilization

IVF is a proven, nonexperimental, medically appropriate and necessary treatment for some forms of the disease of infertility. The procedure has been used for fifteen years, has produced over 23,000 babies in the United States alone and is considered a standard part of the continuum of infertility treatments. Covering infertility treatment but excluding IVF -- the only specific medical protocol on the

* Use of Fertility Services in the United States, Lynne S. Wilcox, MD, MPH, and William D. Mosher, PhD., Obstetrics and Gynecology, Vol. 82, No. 1, July 1993.

exclusion list -- is like covering heart disease through a triple bypass, but excluding coverage if a quadruple bypass is needed. Excluding IVF is unfair and will result in the two tier system of health care that President Clinton is trying to avoid by making it available only to those who can afford to pay for it privately. It is also not justified by the facts and experience of IVF treatment over the past decade:

- Fewer than two percent of people suffering from infertility use IVF; more than 98 percent are treated with more conventional therapies. For this group of patients, however, IVF is medically appropriate and necessary. In some cases it is the only treatment available. IVF is most commonly used to treat women with blocked, damaged or absent fallopian tubes. For these women IVF is the simplest, most successful and most cost-effective treatment. It allows the physician to remove the eggs from the ovary, inseminate them in a petri dish (the term "test tube" baby is incorrect), and place any resultant embryos directly into the woman's uterus thus bypassing the absent or destroyed tubes. Sometimes women with this problem choose to undergo one or several tubal surgeries which is more expensive, riskier to the patient and less successful in terms of pregnancy outcome. It is often the only choice, however, because most insurance will pay for tubal surgery but not for IVF. IVF is the cost-effective and more medically appropriate alternative.

- IVF has a good success rate. The rate of success for IVF is 15-20 percent per cycle. For women whose primary diagnosis is fallopian tube problems, the success rate is even higher. When compared to the 20-30 percent chance that a reproductively healthy couple has of achieving a pregnancy in any given cycle, the IVF pregnancy rate is quite good.

- IVF is self-limiting. IVF is self-limiting because of the rigorous emotional and physical nature of the treatment. Each woman, with her husband and physician, must decide what her most appropriate course of treatment is, but covering IVF will not result in uncontrolled expenditures.

- Excluding IVF will result in a loss of benefits currently available in states that now mandate infertility coverage. Ten states now have mandates that require

insurance companies to cover or offer coverage of infertility treatment. In addition, some employers voluntarily offer infertility coverage to their employees. If the national benefit plan specifically excludes IVF, some residents of these states will lose benefits that they already have. President Clinton has stated many times that no one should be worse off under his plan than before it. That would surely not be the case if IVF remains on the exclusion list.

● Legislating the exclusion of IVF, a specific medical protocol, is neither good medicine nor good public policy. A piece of legislation that will be law for several decades, if enacted, is not the place to determine which specific protocols doctors may use. In vitro fertilization is one of many treatments for infertility and is appropriate and necessary for certain cases. No medically appropriate treatment for the disease of infertility should be excluded from the benefit package.

In recent months the media have reported extensively on a number of new ideas in the field of reproductive endocrinology. We have read about attempts to "clone" embryos (not really what the experiment was about), about women having babies beyond their reproductive years, about the potential of using fetal eggs as donors. All of these procedures or potential procedures would require the use of IVF technology. RESOLVE's position on these developing technologies is that insurance need not cover any experimental procedure. But these extreme instances of IVF usage should not be allowed to deprive hundreds of couples in their childbearing years who might achieve the goal of biological parenthood through IVF from having access to it.

The Cost of Infertility Treatment

The cost of infertility treatment varies greatly from patient to patient depending on the diagnosis and the treatment required. For those needing only a mild hormone drug the cost will be minimal, while those needing tubal surgery will have a significantly higher bill. Couples who remain in treatment for many months or who pursue treatments like IVF can expend tens of thousands of dollars on the

quest for a biological family.

The critical point as you deliberate about health care reform, however, is what is the cost to the U.S. health care budget. Perhaps the best laboratory we have to study what potential costs will be is to look at the experience in the state of Massachusetts. Since 1986 Massachusetts has mandated that all insurers cover comprehensive infertility diagnosis and treatment including unlimited cycles of IVF. In a letter to RESOLVE dated June 4, 1993 Nancy C. Turnbull, then First Deputy Commissioner for the Division of Insurance of the Commonwealth of Massachusetts, stated that all infertility coverage accounted for "~~four-tenths of one percent of the total monthly family premium~~." Factoring out the cost of IVF based on fewer than two percent of patients means that the cost attributable to IVF would be in the hundredths of a single percentage point.

In short, there is no justification based on experience to exclude IVF because of cost. In fact, it is fiscally unsound since some patients are undergoing more expensive, less effective procedures because they cannot afford to pay privately for IVF. There would be a definite savings from less tubal surgery if IVF were covered by insurance.

Summary

Our society places great value on families and there may be no greater instinct in the human species than to create wanted children. When a diagnosis of infertility is made it is a shock to a couple and shakes one of the most basic assumptions we all grew up with: that one day we would become parents. An enormous emotional toll is exacted by infertility as the rollercoaster ride of hope and disappointment goes on for months and even years. In addition to the often arduous rigors of the physical treatment and the emotional upheaval, infertile Americans should not also have to struggle with the financial burden of treatments that are arbitrarily omitted from insurance coverage for no reason based in fact or experience.

We have been told that infertility is not life threatening. But nor are most of the reasons people seek medical care. What people are concerned about is the quality of life and the relief of pain. The quality of life for an infertile couple can be just as severely impaired as that of someone suffering from back pain or requiring arthroscopic surgery or any one of thousands of non-life threatening conditions covered under the national benefit package. The pain of infertility is real and consuming. There is nothing elective about infertility. It is insulting to infertile people to see in vitro fertilization listed with cosmetic surgery and private room accommodations on the exclusion list.

RESOLVE supports health care reform. We believe that all Americans should have access to the medical care they need. The Administration's bill is a step forward where infertility coverage is concerned, but the exclusion of IVF mars our enthusiasm. Medical technology can now offer people who suffer from infertility a chance to have a family. It is unreasonable and unnecessary to restrict access to IVF treatment for those who can benefit from it. **Any national benefit package should include all non-experimental infertility services including IVF.** It will not add significantly to the cost of the package, but will add immeasurably to the lives of those wishing for a child.

I thank the Subcommittee for its interest and hope that we can count on you to include comprehensive infertility treatment, including IVF, in whatever health care plan is passed by the Subcommittee and enacted into law.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Washington D C 20201

NOV 16 1993

Rec'd 11/12/93

Ms. Diane D. Aronson
Executive Director
RESOLVE
1310 Broadway
Somerville, Massachusetts 02144-1731

Dear Ms. Aronson:

Thank you for writing regarding RESOLVE's concern over coverage of infertility services in the comprehensive benefits package of the Health Security Act.

I understand from your letter that you are concerned that the wording of one category of covered services in the comprehensive benefits package, "Family Planning and Services for Pregnant Women," may result in the exclusion of infertility services.

Please be assured that appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language. The comprehensive benefit package under the Health Security Act has broad definitions that will assure coverage for services not itemized in the Act, such as infertility services. The plan covers all services that a clinician has determined to be medically necessary or appropriate unless specifically excluded. The only infertility service excluded from plan coverage is in vitro fertilization.

The Health Security Act lists "Family planning services and services for pregnant women" as a distinct category of services in the comprehensive benefit package to emphasize the importance of family planning and perinatal care within the plan. This benefit distinction does not signify the prohibition of other services that do not fall within the category.

Thank you for expressing your concerns and for your interest in the Health Security Act. We appreciate your support of President Clinton's health reform plan.

Sincerely,

Judith Feder
Principal Deputy Assistant Secretary
for Planning and Evaluation

Testimony
The Susan G. Komen Breast Cancer Foundation
January 26, 1994

Mr. Chairman and distinguished members of the Subcommittee the Susan G. Komen Breast Cancer Foundation appreciates this opportunity to present testimony as you consider the many challenges of national health care reform. As the Subcommittee reviews the women's health issues and health care reform legislation, we urge you to ensure that routine mammography screening is included according to the guidelines currently recommended by the National Cancer Institute. The Komen Foundation is pleased to share its priorities for health care reform and to educate the Subcommittee about our efforts to promote breast cancer awareness and find a cure for this devastating disease.

Komen and Its Mission

The mission of the Susan G. Komen Breast Cancer Foundation is to eradicate breast cancer as a life threatening disease by advancing research, education, screening and treatment. Nancy Brinker founded the Foundation in 1982 in memory of her sister, Susan G. Komen, who died of breast cancer at age 36. Since then, the Komen Foundation has grown into a thriving, vertically-integrated, volunteer-driven organization that works actively at the national, state and local levels to eradicate breast cancer as a life-threatening disease. The Komen Foundation is a national network of volunteers working through local chapters and RACE FOR THE CURE events, next year in at least 46 cities, representing 29 states and the District of Columbia. With over \$19 million raised since its inception, the Komen Foundation is one of the largest private foundations funding breast cancer research, education, screening and treatment efforts. At the conclusion of this statement is a summary of highlights of the Komen Foundation's efforts at the national, state and local levels.

Health Care Reform Priorities

♦ **Access to Care**

Komen commends the Clinton Administration's leadership in tackling the myriad complex and challenging issues presented by health care system reform. In particular, we support guaranteed access to health care for every American and inclusion of a comprehensive minimum benefit package. In the future, women facing breast cancer will be able to take comfort in knowing they will enjoy access to needed hospital, outpatient, laboratory and diagnostic services, prescription drugs and biologicals, and the services of physicians and other health professionals, as well as new supports for home health care.

Testimony by the Susan G. Komen Foundation November 15, 1993

• **Coverage of Routine Mammography Screening**

Mammography screening, in combination with a clinical breast examination, is currently the most reliable tool for detection of breast cancer in its earliest and most treatable stages. Therefore, screening and clinical breast exams must be accessible and available to all individuals according to current National Cancer Institute recommended guidelines.

While the Komen Foundation endorses the strong preventive services component in the President's plan, we are very concerned that the present proposal precludes access to routine mammograms until a woman reaches age 50. I think it is imperative that health care reform includes mammography coverage for women 40 to 49 years of age until further studies examine the efficacy of screening this age group. No definitive study is currently available, although we understand that Britain has a significant study underway.

If women under 50 have access to routine mammograms only in situations indicating need for diagnostic mammograms because of known risk factors or symptoms, the "reform" is potentially an enormous step backwards for the health status of American women in the 40-49 age category. Adequate screening must be available to women early enough to detect cancer when it is treatable. The new draft federal policies on mammography (released October 1, 1993) present an unconvincing rationale and insufficient justification to change the current NCI screening guidelines. Komen's view is that health care decisions should be based strictly on clinical data without undue consideration to health economics.

Changing the NCI screening guidelines now will result in greater confusion about the appropriate frequency for mammography screening. This makes no sense in the midst of a growing breast cancer epidemic. Private and public sector efforts alike over the past decade have targeted screening and early detection efforts particularly at women age 40 and older. Sacrificing the small strides forward -- in the absence of solid scientific evidence -- is shortsighted, at best!

Komen's recent experience exemplifies the need for consistent, scientifically sound federal mammography guidelines. The Komen Foundation has received reports from around the country that women are canceling appointments for mammograms because they no longer feel annual mammograms are necessary in light of news of the changing guidelines. The federal government must not continue to send conflicting signals to women about the need for mammography screening.

We know that early detection saves lives and money. With education, early detection and follow-up, 30 percent of breast cancer deaths could be prevented and substantial treatment costs saved. According to the Centers for Disease Control and Prevention, breast cancer found in its earliest stages can be treated for \$14,000 versus \$84,000 or more for advanced cases.

The Komen Foundation recommends that before federal policies on mammography are revised, adequate studies must be undertaken and completed. Until adequate scientific evidence is obtained, the current NCI and American Cancer Society (ACS) recommendation that women from 40-49 should receive mammograms every one to two years, should be retained. Any health plan passed by Congress should include this coverage in the standard schedule for clinical prevention services.

Testimony by the Susan G. Komen Foundation November 15, 1993

• **Coverage of Experimental Drugs and Treatments**

The Komen Foundation supports the inclusion of coverage for patient costs associated with clinical trials in the comprehensive benefits package proposed by President Clinton. In addition, when such treatments are appropriately prescribed by a physician, coverage must extend to all costs associated with FDA approved anti-cancer drugs, biologicals, and new investigational therapies, for their approved indications, for indications listed in the compendia, and for indications approved by peer review literature.

• **Research**

The federal government must continue to strengthen its investment in breast cancer research. We strongly support high priority research on the development of better indicators of early signs of the disease, including blood, urine and other tests to detect early genetic markers of breast cancer.

Both basic and clinical cancer research must receive funding from consistent and reliable sources at appropriate levels. The Komen Foundation believes that highest priority must be placed on funding for research into the causes and methods of prevention, early detection, and treatment of breast cancer. In addition, programs must be fostered to provide incentives, mentoring and encouragement to young scientists to work in the area of breast cancer research to cultivate and support innovative research ideas.

• **Insurance Reforms**

We applaud President Clinton for including fundamental insurance market reforms in the Administration's health care reform legislation. We support reforms which ensure that all individuals have the opportunity to purchase affordable comprehensive health insurance, which includes coverage for screening, diagnosis, treatment and follow-up for breast cancer. In particular we hope that any health reform package which is enacted by Congress eliminates preexisting condition exclusions and guarantees enrollment, renewability and portability of health care coverage.

Conclusion

The Komen Foundation fully recognizes the difficult decisions that the Congress faces in trying to reform our health care system and make it function within the severe budget constraints that exist. Such constraints make critical the need to invest wisely the scarce dollars we do have.

From our vantage point, we have seen tremendous benefits resulting from effective, widespread education and early detection efforts. Remember, money invested near-term to promote breast health practices, such as breast self-examination, and screening mammography, will save money and lives long-term. Last year witnessed the loss of 46,000 women's lives to breast cancer alone. The financial impact of their treatment, lost wages, loss to their families of care givers, and loss to our economy of trained, productive and valuable citizens cannot be easily dismissed.

When we budget, we always seem to have the funds for the items we put first. Surely the opportunity to save significant numbers of lives, reduce the ultimate cost in dollars as well as

Testimony by the Susan G. Komen Foundation November 15, 1993

pain and suffering, and build the infrastructure for health care for the future must be at, or near, the top of our list.

Thank you for your time and attention, and for considering the lives of millions of women and their loved ones. We invite you to join us -- early and always -- in the RACE FOR THE CURE for breast cancer.

The Susan G. Komen Foundation

In addition to supporting a balanced program of breast cancer research and promoting the importance of screening for detection of the disease, the Komen Foundation concentrates on programs to promote awareness and education of breast self-examination, detection and treatment options. Central to our program is a commitment to meet the needs of the underserved, minorities, and those least able to access health care. Through a variety of community-based efforts, the Komen Foundation works to eliminate financial, institutional, and cultural barriers to screening and treatment services. The Foundation's particular strength is its ability to create coalitions of health care facilities and providers, private/public partnerships, and volunteer-staffed model programs to provide education and awareness activities that improve access to care for breast health for all women. The most prominent of Komen's education and awareness activities include:

◆ **RACE FOR THE CURE®**

Key to the Komen Foundation's phenomenal growth in recent years is its highly successful RACE FOR THE CURE® series of 5K/1 mile race walks throughout the United States. Since the first RACE in Dallas in 1983, the series ballooned to RACES in 35 cities across the country with 125,000 participants in 1993, and we expect to run at least 46 RACES in 1994.

From each RACE, 25% of the proceeds fund national research grants, and 75% of the money remains in the RACE city for various local projects. Generally the projects involve screening, establishment of breast health centers, bilingual outreach, hospital programs such as "patient navigators" to help underserved women through the diagnosis and treatment process, and other efforts to bridge the gap between detection and treatment of breast cancer.

◆ **National Helpline**

The Komen Foundation's national helpline (1-800-I'M AWARE) uses trained volunteers to assist callers with breast health and breast cancer concerns by providing information on health and disease issues, local and regional resources, and available and affordable services.

◆ **Leadership Summits on Breast Cancer**

Since 1989 the Komen Foundation and the National Cancer Institute (NCI) have co-sponsored Leadership Summits on Breast Cancer nationwide. These Summits promote public/private partnership and encourage community-based and regional programs for awareness, screening, and treatment of breast cancer.

◆ **Biennial Symposium on Minorities and Cancer**

Earlier this year, the Komen Foundation co-sponsored The Fourth Biennial Symposium on Minorities, the Medically Underserved and Cancer, held in April in Houston, Texas. The Symposium focused on health care access, including lack of insurance, language barriers, location of health facilities and issues of employability when diagnosed with a catastrophic illness.

◆ **National Government Relations Program**

Among our efforts at the national level, the Komen Foundation works cooperatively with other cancer groups to secure substantial increases in federal funds for breast cancer research and screening. We also have played major roles in the enactment of the Mammography Quality Standards Act of 1992 and in the funding of its implementation for 1993 and beyond.

TESTIMONY OF JUDITH L. LICHTMAN,
 PRESIDENT OF THE WOMEN'S LEGAL DEFENSE FUND,
 BEFORE THE COMMITTEE ON ENERGY AND COMMERCE,
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

"The President's Health Plan and Women's Health"

January 26, 1994

The Women's Legal Defense Fund has worked for two decades to secure reproductive freedom, fight job discrimination, help Americans balance work and family responsibilities, give women access to quality health care, improve women's economic status, and reform the nation's child support system.

First, we want to thank Congressman Waxman for holding this hearing on women's health. Women's health care is at a critical and defining moment. We must not underestimate the far-reaching ramifications of policy decisions that will be made over the next several months. The President and this Congress are poised to dramatically reshape our nation's health care system. The outcome of this process will determine for decades to come what health care services women have (and do not have) access to.

For the first time, all women (and men) will be guaranteed access to a nationally set package of health care services, including essential preventive services. Decisions about what is in that package must be based on what is needed to protect our health and well-being. We must not let limited resources work to deny women their most basic health care needs. All women, particularly low income women and others who historically have had difficulty obtaining needed health care services, will be looking to this Congress and to the President to do the right thing.

We emphasize this point because there is a long history of women's health issues being given short shrift in this country. There has been a paucity of research into women's health needs and a disgraceful lack of progress in understanding, preventing and treating diseases that primarily affect women. The historical failure to include women in clinical research trials and to conduct research on conditions primarily affecting women has left major gaps in our knowledge about women's health needs. In the past few years, attention has finally begun to focus on the appalling lack of research into women's health needs, even capturing the attention of the media. But, nevertheless, we have a long way to go.

We raise this point also because women's health care services, and most especially their reproductive health care services, traditionally have been fragmented, isolated and marginalized in ways that negate the integral connection between

women's reproductive health and their general health and well-being.

And finally, we make this point because decisions about women's health, especially reproductive health, are all too often determined by politics and what are perceived to be the prevailing winds of public opinion, rather than sound medical judgment and desired health outcomes.

For women to participate in this society on an equal footing with men, their health needs must be met. This means that this country must make a commitment to know more about women's health care needs and to ensure that women benefit from advances in scientific research and technology, including the most effective ways to detect and treat conditions that affect women. We must commit to ensuring that women have access to the highest standard of services. We must meet the health care needs of all women, especially those who historically have been shut out of the system.

For health care reform to be effective and complete, it must embrace the following key principles:

1) It must provide universal coverage. We cannot provide care for only some of the people, some of the time. We must ensure that all have access to care, regardless of whether or where they work, with whom they live or how sick they are or may become.

2) It must ensure access to comprehensive benefits. We cannot include some of the health services that women need and exclude other essential services.

3) It must emphasize preventive services, services that can dramatically improve health, end unnecessary suffering and save money down the line.

4) Health care must be affordable, especially for those who currently fail to get needed care because it costs too much. This will mean lifting all financial barriers that impede access to care, in part through creating an adequate and fair network of subsidies for low income people.

5) It must ensure that people receive quality care, not just for those with means, but for all.

6) It must provide the security of knowing that affordable health care will always be there when you need it, regardless of whether or where you work, whether you change jobs or lose your job, with whom you live or how sick you are or may become.

7) It must ensure that people have choices in deciding who provides their care.

The Health Security Act (H.R. 3600/S. 1757) goes a long way toward meeting these critical objectives for reform. Passage of this legislation would be a tremendous step forward for women and their families.

Judged against the principles outlined above, the Administration's proposal generally fares well:

1) HSA's promise of universal coverage is undoubtedly the most critical aspect of this legislation.

2) HSA's promise that all women (and men) will receive the services spelled out in the comprehensive benefits package is another critically important aspect of this legislation.

3) HSA's focus on preventive health care is long overdue and will undoubtedly help to improve health status, eliminate human suffering and reduce costs.

4) HSA provides coverage regardless of health status or pre-existing condition.

5) HSA integrates Medicaid within the major delivery system and provides subsidies for low income people, and thus goes a long way toward getting rid of our current two-tiered system -- on the path to ensuring that all, regardless of income, will receive comprehensive health care services.

6) HSA aspires to ensure quality care, though questions remain about how well this goal has been accomplished.

7) HSA provides a measure of health security -- a guarantee that health care will be there when you need it.

8) HSA provides enrollees with choice among plans and providers.

Despite the good news, there are some important shortcomings in the HSA. In our evaluation of the HSA, the Women's Legal Defense Fund focused on issues that are of specific importance to women. These issues include (but are not limited to):

- 1) coverage of the full range of reproductive health services;
- 2) coverage of long term care;
- 3) coverage of mental illness and substance abuse services;
- 4) coverage of prescription drugs;
- 5) concerns of low income women (subsidies for low income people and the impact of mainstreaming Medicaid);

- 6) the impact of the HSA on women due to their family status;
- 7) the impact of the HSA on women due to their employment status;
- 8) civil rights protections for women and people of color;
- 9) health research priorities; and
- 10) confidentiality issues.

Below we discuss each of these areas and our major concerns about the HSA.

Reproductive Health Services

The HSA provides for coverage of a wide range of reproductive health services, including:

- * prenatal care, delivery services and post-partum care
- * family planning services (including FDA-approved prescription drugs and devices)
- * sterilization services
- * infertility services (except for in-vitro fertilization, which is explicitly excluded)
- * abortion services
- * annual screening for chlamydia and gonorrhea available free for women at risk
- * diagnosis and treatment for all sexually transmitted diseases
- * cancer screening tests such as Pap smears, clinical breast exams and mammograms (subject to specific age and frequency limits)
- * diagnosis and treatment for cancers of the reproductive organs

We applaud the Administration's inclusion of these critically important services in the comprehensive benefits package. Nonetheless, some improvements are needed in the reproductive health package.

Because these services are so basic and essential to women's health, it is critical that HSA include a guarantee that all these services will be provided in each health plan's network of providers. The lower cost sharing plans and the mid-level combination cost sharing plans contemplate that enrollees may at times need to go outside the plan's network to obtain essential services when such services are not available in their plan. However, this would entail additional costs. Women should not be required to pay additional costs to obtain access to basic services; for low income women, such costs may be prohibitive and act as a barrier to obtaining needed care. Once again, we would find ourselves trapped in a two-tiered system of care.

HSA allows "a health professional or a health facility" to decline to provide any services if the provider objects to providing such services on the basis of a religious belief or moral conviction. (Section 1162) This so-called conscience clause will undoubtedly affect the provision of reproductive health services, from family planning services to sterilization services to abortion services. While we agree that a conscience clause for health care providers is appropriate, the conscience clause in the HSA is written in so broad a manner that it has the potential to deny huge numbers of women access to needed care. It is imperative that this language be refined to ensure that it applies only to individuals and private institutions that are religiously controlled, not to public institutions at all.

Another major shortcoming in the HSA's provision of reproductive health services is in screening for breast and cervical cancer. HSA contains age and frequency limits on clinical breast exams, Pap smears and mammograms that fall short of the recommendations of the American Cancer Society and the majority of medical and scientific organizations that have screening guidelines. The importance of early detection cannot be overstated: early detection and improved treatment for breast cancer have kept death rates stable despite increasing rates of incidence; the death rate for cervical cancer has declined more than 70 percent, due primarily to regular checkups and Pap smears.

While it is extremely positive that preventive cancer screenings would be provided free of charge, it is nevertheless essential that they be provided with adequate frequency. If "prevention" is an integral and cost-effective tenet of this system, then we must provide enough of it to be effective. To do otherwise is like installing one smoke alarm in an eight-story building. Toward that end, existing American Society guidelines for cancer screening must be followed until such time as adequate research has been done that would justify any change in current recommendations.

Furthermore, for preventive services to be truly effective, it is essential that they be made available with as few barriers or disincentives as possible. This means providing them without co-payments or deductibles. HSA recognizes this and provides prenatal care and what it calls "clinical preventive services" free of charge. Nevertheless, HSA fails to cover a critical aspect of women's reproductive health care in this manner. It does not cover family planning services -- the quintessential preventive service -- in this manner.

¹ American Cancer Society, Cancer Facts & Figures - 1993, pp. 11-14.

Another shortcoming in HSA's coverage of family planning services is the failure to state explicitly that voluntary sterilization services and contraceptive drugs are covered family planning services.

Finally, although HSA provides for a very comprehensive range of reproductive health services to be covered, it explicitly excludes in vitro fertilization, which is an essential service required by a small minority of infertile couples. While in vitro fertilization and similar treatments account for less than five percent of infertility services, they are essential services for couples for whom no other treatment is available.² This omission should be corrected.

Long Term Care

Long term care is an aging issue; it is a family issue, and it is a women's issue. One third of people needing long term care are children or younger adults, and the burden of their care falls generally on women. Not surprisingly, women are more likely than men to need long term care and to be the caregivers of such services. Whether recipients of such care or caregivers themselves, women need health care reform to address long term care services.

WLDF is glad to see that HSA makes a start toward providing critically needed long term care services through a program of home and community based services. A range of services -- from adult day care to respite care to rehabilitation services -- would be available under this bill to eligible individuals. Eligibility would depend on degree of impairment and would include both mental impairment as well as need for assistance with activities of daily living.

Unfortunately, however, these services are not currently proposed as part of the comprehensive benefit package, but rather as a separate block grant program. This will limit the amount of money states have to provide these services and give states considerable discretion in deciding what services to provide and to whom. Receipt of services will thus depend on annual appropriations, the vagaries of politics and on state program design. Nor is nursing home care covered under this new program, a shortcoming with significant ramifications for women, who constitute the bulk of nursing home residents. HSA does,

² The American Fertility Society, Infertility: Questions and Answers (November 1993).

³ Testimony of Stephen McConnell, Alzheimer's Association, Representing the Long Term Care Campaign, before the Committee on Ways and Means, Subcommittee on Health, November 2, 1993.

however, make some improvements in Medicaid eligibility for nursing home care for those poor enough to qualify for Medicaid.

Mental Illness and Substance Abuse

HSA rightfully recognizes that services for mental illness and substance abuse must be provided. For women, these services are especially important. According to a recently published study, women are much more likely than men to suffer from depression or anxiety disorders. Although women are much less likely to suffer from substance abuse than men, women, especially pregnant women, often have great difficulty finding alcohol and drug treatment programs.

The bill wisely covers services in a wide range of settings, including inpatient and residential treatment, intensive nonresidential treatment, and outpatient services. Although varied eligibility requirements apply to these services, all persons will have access to screening, assessment and crisis services. Family members can receive "collateral services" to help them cope with their loved one's mental illness or substance abuse, but only if the family member with mental illness or a substance abuse problem is in treatment.

While we applaud the Administration for including these services, we are nonetheless extremely concerned about the day/visit limits on coverage and about the high co-payments that would be required for this type of care. These barriers will prevent many people from getting effective treatment. We also believe that collateral services (discussed above) should be available even if the family member with the problem is not in treatment. We also are concerned that by lumping together mental illness and substance abuse services, people needing both kinds of services will not get the care they need.

Prescription Drugs

Coverage of prescription drugs is important to women's health. Women use prescription drugs more than men, and the elderly, especially elderly women, are the largest users of prescribed medications.⁵ Elderly women constitute 11 percent of

⁴ Ronald C. Kessler, PhD., et al., "Lifetime and 12-Month Prevalence of DSM-III-R Psychiatric Disorders in the United States," The Archives of General Psychiatry, Vol. 52 (January 1994), pp. 8-19.

⁵ Families USA, Prescription Costs: America's Other Drug Crisis (September 1992), p. 2.

the population, yet 25 percent of all drug prescriptions are written for them.

HSA provides coverage for prescription drugs in two ways: as one of the benefits in the comprehensive benefit package; and as a new Medicare benefit. While we applaud inclusion of these benefits, we are concerned that required co-payments may render this benefit of little use to many individuals. For those who are part of the alliance system, one of the cost-sharing plans has a \$250 prescription drug deductible for each individual in the family before the plan will cover the costs of prescription drugs. For those on Medicare, the possibility exists that out-of-pocket costs for drugs could reach \$1,000 per year. Since the average annual income of women over the age of 65 is approximately \$8,044,⁶ these costs could prove prohibitive.

Primary Concerns of Low Income Women

Adequate health care is central to the vitality of low income families. Members of low income families are more likely to experience serious health problems such as heart disease and diabetes, and infectious diseases like tuberculosis. Poverty is unfortunately a women's issue. About one third (34.9 percent) of families headed by women have incomes below the poverty line, compared to 15.6 percent of households headed by males and 6.2 percent of married-couple households. Over half of all poor families (52.4 percent) are headed by women. A disproportionate number of these families are headed by women of color. How reform treats these low income families is a critical measure of success.

There are some positive ways in which low income families will fare under the HSA. First, we are glad to see that Medicaid beneficiaries will receive health care through the alliances like everyone else; this is an important step in ending our two-tiered

⁶ The Jacobs Institute of Women's Health, The Women's Health Data Book (Jacqueline A. Horton, Sc.D., ed., 1992), p. 82.

⁷ Testimony of Joan A. Kuriansky, Chair, Campaign for Women's Health, before the House Ways and Means Committee, November 15, 1993, p. 2.

⁸ Testimony of Diane Rowland, Sc.D., Senior Vice President, Henry J. Kaiser Family Foundation and Executive Director, Kaiser Commission on the Future of Medicaid, before the Committee on Energy and Commerce, Subcommittee on Health and the Environment, November 19, 1993, pp. 2-3.

⁹ Bureau of the Census, Poverty in the United States: 1992, p. xv.

health care system. Second, HSA provides subsidies for plans at or below the weighted average premium, and will thus allow low income people to choose from plans up to the average cost plan. While this will keep low income people in the cheaper plans, at least it does not keep them in the lowest cost plan.

Despite these good points, there are problems with HSA's treatment of low income people, especially low income pregnant women.

1. Subsidies

HSA contains a complex array of provisions dealing with subsidies for low income individuals. Concerns about these provisions include:

a) Premiums are waived for AFDC/SSI recipients who will have varying levels of income depending on what state they live in. Income levels, not receipt of public assistance, should govern eligibility for subsidies.

b) The premium subsidies are not adequate, especially for some categories of part-time workers. (See discussion of employment-related issues.)

c) Premium subsidies only help with the purchase of up to the average priced plan. The lack of subsidies for higher priced plans will keep low income people in the cheaper plans. (Nonetheless, as mentioned above, we are glad to see that low income people are not relegated to the lowest cost plan.)

d) Co-payments are reduced only for AFDC/SSI recipients, but even these reduced co-payments exceed current Medicaid co-payments. Low income families who do not receive AFDC/SSI would be required to make the same co-payments as more affluent people enrolled in the lower cost sharing plan.

e) In addition to inadequate premium subsidies, lack of assistance with co-payments will effectively keep low income people in the lower cost sharing plans.

f) HSA requires lower cost sharing plans (generally closed panel HMOs) to offer enrollees the option of choosing providers outside the plan's network. An additional unspecified premium will be charged for this option, but it is not clear whether premium subsidies would be available to purchase this option. The out-of-network option also requires the payment of higher co-payments. If low income people do not get premium subsidies or adequate assistance with co-payments for out-of-network services, they will be locked into closed panel HMOs.

g) The maximum out-of-pocket limits for all services are absolute dollar amounts; they are not related to income level. This means that a much bigger chunk of a lower income person's family income can be required to go for health care.

h) Poverty level and family size definitions discriminate against families with more than two children. For other federal programs, poverty level is adjusted for family size, because larger families need more income to avoid poverty. However, for HSA purposes, all families are, in effect, deemed to have no more than two children. Thus, larger families -- who may have higher incomes but still be poor under federal poverty guidelines -- may not qualify for a subsidy.

2. Impact of Mainstreaming Medicaid on Pregnant Women

Great progress has been made over the past decade in de-linking Medicaid from eligibility for welfare and in providing health care through the Medicaid program for low income pregnant and post-partum women. These improvements have resulted in Medicaid coverage of pregnant and post-partum women whose family incomes are as high as 275 percent of poverty.¹⁰ This coverage is provided at no cost to the woman. Under the HSA, however, because the Medicaid program is eliminated for non-cash recipients, these women will be required to pay for their premiums, with the amount depending on their employment status and the level of their income.

In addition to medical services, states currently have the option to provide supplemental services such as transportation, nutritional counseling and home visiting to all Medicaid-eligible pregnant and post-partum women (not just to those who are on Medicaid because they receive AFDC).¹¹ Under HSA, supplemental services will continue only for those who receive Medicaid because they receive AFDC. This represents a loss of services

¹⁰ Under current law, states must cover pregnant women with incomes up to 133 percent of the poverty level, with the option to expand this coverage to those with incomes up to 185 percent of poverty. According to the National Governors' Association, 34 states have expanded eligibility above the mandated level of 133 percent; two states, Minnesota and Vermont, have taken advantage of further flexibility to expand their income limits to 275 and 200 percent of poverty, respectively. National Governors' Association, State Coverage of Pregnant Women and Children - July 1993, Table 1.

¹¹ According to the NGA, 37 states currently provide home visiting, 36 states provide nutritional counseling, and 12 states provide transportation. National Governors' Association, State Coverage of Pregnant Women and Children - July 1993, Table 10.

for pregnant and post-partum women who are not AFDC recipients but are nonetheless currently eligible for Medicaid, services that can be essential for access to care for this vulnerable population.

Family Status Issues

Family status is a central concept in the HSA; premiums are allowed to vary only by family status (individual, couple, single-parent family and dual-parent family). As a result, how one's family is categorized will determine the premium each family (and employer) will pay. We have some concerns about how families are defined as well as how changes in family composition would affect responsibility for payment of premiums under the bill.¹²

As currently proposed, the couple class and the dual-parent family class require that the partners be married (as defined by state law), which will virtually preclude unmarried heterosexual, gay and lesbian couples from qualifying for these classes. Partners who are not married will be disadvantaged if the sum of the premiums for two individuals exceeds the premium for a couple (the Administration estimates that it will not), or if the sum of the premiums for an individual and a single parent (or two single parents) exceeds the premium for a dual-parent family (the Administration estimates that it will).

Given the importance of family status to the premium structure, it is surprising that HSA contains no specifics about how changes in family composition will affect payment of premiums. Instead, HSA provides that such issues will be determined by the National Health Board.

Employment Status Issues

1. Women in the Workforce

Under our current health care "system," where health insurance status depends on whether one's employer chooses to provide insurance, women are disadvantaged. Women comprise most of the growing "contingent" workforce in the U.S., which at an estimated 3.9 million employees is the fastest growing segment of our labor force. Contingent workers include part-time, temporary, contract and casual employees. The Bureau of Labor Statistics reports that over two-thirds of all part-time workers

¹² Our major concern is not whether changes in family composition will affect receipt of health care services -- because continuation of services is guaranteed -- but rather how changes in family composition will affect who pays what premium. HSA leaves these questions unanswered.

are women; twenty-five percent of all working women work part-time. ¹³ More than three-fifths of all temporary workers are women. Many of this country's seasonal agricultural workers are women.

Legions of contingent workers lose out on the benefits that are often taken for granted in full-time employment -- benefits that include seniority-based compensation, pensions, and significantly, health insurance. Only 23 percent of temporary employees and 22 percent of part-time employees receive health insurance benefits through their employers. ¹⁴ Moreover, the Bureau of Labor Statistics reports that only five percent of part-time workers in firms with less than 100 employees have employer-provided health care coverage. ¹⁵

In addition, even if they work full-time, women on average work for lower wages than men and are more likely to work in jobs that do not carry health insurance benefits. Women are disproportionately represented in jobs paying \$20,000 per year or less: nearly 70 percent of all women workers earn less than \$20,000 per year and 40 percent of all women workers earn less than \$10,000 per year. ¹⁶ New data shows that 32 percent of U.S. workers earning less than \$10,000 per year lack health insurance coverage of any kind. A full 88 percent of the uninsured are in families with an estimated adjusted gross income of less than \$20,000 per year. ¹⁷

Women are the majority of workers in the growing service-providing industries and in smaller firms, which have the lowest rates of providing benefits. For example, women hold more than 52 percent of the nation's retail trade jobs and 62 percent of service industry jobs (working in industries such as hotels, personal services, educational and social services, and health

¹³ Economic Policy Institute, New Policies for the Part-Time and Contingent Workforce (Virginia L. duRivage, ed., 1992).

¹⁴ Economic Policy Institute, New Policies for the Part-Time and Contingent Workforce (Virginia L. duRivage, ed., 1992).

¹⁵ U.S. Department of Labor, Bureau of Labor Statistics, reported in Daily Labor Report, No. 18, p.B-7 (January 28, 1994).

¹⁶ U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P60-184, Money Income of Households, Families, and Persons in the United States: 1992.

¹⁷ Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994).

services).¹⁸ A typical service sector job is in a smaller-sized firm, pays little better than the minimum wage, and does not provide health insurance coverage. Thirty percent of employees working in firms with less than ten employees are uninsured.¹⁹

It is these low-wage workers -- contingent workers, service industry workers and those in small firms -- who can least afford to buy health insurance for themselves and their families without employer assistance.

2. HSA's Impact on Women in the Workforce

HSA would build on our current system in many respects by retaining the link between employment and insurance. A major improvement to our current system is HSA's requirement that employers -- even small employers -- contribute to the cost of their employees' health insurance. Coverage of small employers will benefit women and their families enormously. However, a major problem in the HSA is its failure to define "employee" to determine who is an independent contractor and who is an employee. Since employers are only required to contribute towards the premiums of "employees" and not independent contractors, this classification makes a significant difference in who pays how much.

HSA's impact on women who work in small businesses is clear: they would be covered. We also have carefully evaluated HSA's impact on other categories of workers to see how they would fare under HSA: part-time workers, temporary employees, and seasonal workers.

a) Part-time Workers

We have generally found that HSA does a good job of addressing the needs of many part-time employees. Although part-time workers would be required to pay some part of the employer's unpaid share, HSA's income-based caps would kick in to limit the total amount many part-time workers would have to pay towards their premiums. The type of part-time worker who will not fare well under the HSA is the part-time worker who works less than 40 hours a month for one employer. Such day workers or casual laborers would generally be responsible for the entire employer

¹⁸ U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings (January 1991).

¹⁹ Employee Benefits Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994).

share (in addition to the family share), subject to income-based caps.

b) Temporary Workers

Temporary workers stand to gain significantly under the legislation because they would be considered employees -- either part-time or full-time -- of the temporary agency that hires and places them. Temporary agencies and employee leasing companies would be covered by the employer mandate and therefore be required to make employer contributions for each qualifying employee.

c) Seasonal Workers

The plan is most ambiguous in its coverage of seasonal workers. Theoretically, seasonal workers would be covered in the same way as other part-time or full-time employees, with employers being obligated to make contributions. However, the nature of seasonal work -- with erratic work schedules that fluctuate widely from month-to-month (particularly for agricultural workers who move from employer to employer within a season of employment) -- may mean these workers would fall through the cracks without any employer contributions.

Similarly, the plan does not adequately address the geographical or cross-regional alliance changes that inevitably happen during a work season for agricultural workers. A seasonal worker could lose coverage if she leaves an alliance for more than 6 months and does not join a new alliance.

In addition, even though the plan seeks to provide universal coverage, the HSA specifically excludes undocumented workers. Many farmworkers working for U.S. employers have no documentation. Many child care and elder care workers are also undocumented. By excluding undocumented workers, HSA denies coverage to these workers' families as well; indeed, even American-born children may be excluded from eligibility under the current proposal.

Civil Rights Protections

HSA contains many provisions that purport to ban discrimination by health alliances, health plans and states. While we emphatically agree about the need for such protections, unfortunately there are many shortcomings in the provisions contained in the bill. For example, some of the provisions fail to include sex as a protected class. Others ban intentional discrimination, but fail to ban conduct that has discriminatory effects. Few of the provisions apply to actions by regional and corporate alliances. Moreover, there is no provision for data collection to ensure that the entities governed or regulated by

the HSA are in compliance with the antidiscrimination provisions.²⁰

Research Priorities

HSA lists a few specific diseases or conditions that will require research: Alzheimer's disease, breast cancer, heart disease and stroke. It also list several more general categories of research priorities:

- * child and adolescent health (including birth defects)
- * chronic and recurrent health conditions
- * reproductive health
- * mental health
- * elderly health
- * substance abuse
- * infectious diseases
- * health and wellness promotion
- * environmental health

While we do not take issue with the general categories listed in the legislation, more details about research priorities would be preferable. Important areas for research include: contraceptive development; research on conditions that primarily affect women (such as osteoporosis and menopause); development of methodologies to account for women's reproductive capacities and other gender differences as variables in the conduct of research; and data collection and analysis adequate to assess gender differences in all research projects.

Confidentiality Issues

WLDF's major concern is that services be provided to family members confidentially. Confidentiality in medical care is essential, whether it is for an adolescent who needs birth control or treatment for a sexually transmitted disease, or for a woman in an abusive and faltering marriage who is unable to share with her husband information about a private medical condition.

There are no provisions in the HSA guaranteeing intra-family confidentiality. The confidentiality provisions in the bill deal with maintaining the privacy of information collected as part of the health information system established by the National Health

²⁰ For a fuller discussion of the shortcomings of the HSA's civil rights provisions, see Testimony of Marcia D. Greenberger, Co-President, and Verna Williams, Senior Counsel, National Women's Law Center, before the Committee on Energy and Commerce, Subcommittee on Health and the Environment, January 31, 1994, presented on behalf of the National Women's Law Center and the Women's Legal Defense Fund.

Board. Intra-family confidentiality guarantees must be added to the legislation.

* * * * *

The stage is now set for what will be the most dramatic and far-reaching social reform this nation has experienced in decades. As we begin the very difficult and challenging process of defining and shaping the exact nature of these reforms, we must ensure that women's health care needs are adequately met.

This Subcommittee's willingness to listen to our concerns gives us hope that our needs and concerns will not become political fodder to be bargained away. We face an extraordinary opportunity to improve the health of the people in this nation, and with your continued help and vigilance we will not squander that opportunity.

HEALTH CARE REFORM

Public Health, Consumer Protection, Civil and Privacy Rights

MONDAY, JANUARY 31, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order. Today we continue our examination of President Clinton's Health Security Act. The focus of today's hearing is threefold, public health, consumer protection, and civil and privacy rights.

Everyone acknowledges that any health care system must be built on a foundation of public health. No one believes that an insurance card can stop a TB epidemic or clean up unsafe water supplies, and no one believes that an insurance system can stay solvent if it must keep paying to treat sicknesses that could be prevented. In many ways, the best effort at cost containment that we can produce with this health reform legislation would be a strong public health system that prevents disease and disability.

Unfortunately, the President's proposal provides only a shell of such a system. While the Health Security Act outlines broad initiatives, it provides no funding for these programs and in fact makes current shortfalls more intense by lumping this new spending in with ongoing efforts. This sort of robbing Peter to pay Paul approach is the hallmark of failed public health programs in the past and has produced unsuccessful AIDS policies, a return of tuberculosis and measles, and a collapse of the safe drinking water supplies. We cannot repeat this mistake and call it progress.

After the public health testimony, we will next turn to the provisions in the President's bill that are designed to ensure that consumers receive the services they are promised. The basic premise of the bill, of course, is that competition among managed care plans will squeeze inefficient providers and inappropriate care out of our health care system, thereby restraining costs. The issue is the adequacy of protections in the bill to assure that as the plans squeeze, consumers are not denied access to appropriate needed care to which they are entitled. Without adequate consumer protections, health care coverage will be there, but actual services may not.

Finally, we want to look at whether the President's plan adequately protects the privacy rights and civil rights of all Americans. In part this issue has already come up. During last week's hearing on the impact of the Clinton plan on special populations, the National Council of La Raza testified in opposition to the bill as introduced on the grounds that the Health Security Card would pose, and I quote, "An enormous threat to the civil rights and dignity of the Nation's 25 million Latinos, nearly ½ of whom are currently uninsured." We want to be sure that in enacting health care reform, we do not undermine the civil or privacy rights of all of our citizens.

I want to ask unanimous consent that all Members be permitted to enter an opening statement in the record at this point.

Our first witness this morning is Dr. Philip R. Lee, the Assistant Secretary for Health in the Department of Health and Human Services. He is accompanied by Nan Hunter, Deputy General Counsel to the department and a nationally recognized expert on individual rights.

We are pleased to welcome the two of you to our hearing today. We are looking forward to your testimony. Without objection, your written statement will be included in the record in full. We would like to ask you to proceed.

STATEMENT OF PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH, PUBLIC HEALTH SERVICE, ACCOMPANIED BY NAN HUNTER, SPECIAL ASSISTANT TO THE GENERAL COUNSEL

Mr. LEE. Thank you very much, Mr. Chairman. Let me just take a few moments to summarize the statement. I think the most important point to be made is that the President's plan proposes significant strengthening of the public health infrastructure and linkages between the public health system and the personal health care system to achieve public health objectives which have been outlined in Healthy People 2000.

First, to improve the health of all Americans, and second, to reduce the health disparities among Americans. Through these measures we will provide real health security, not just an approach to financial security.

In the statement, I do include a discussion of quality issues which will be the subject of subsequent hearings and I simply want to submit that for the record at this point in time.

Mr. WAXMAN. Without objection, we will receive it for the record.

Mr. LEE. Thank you. Let me just say a few words about the public health initiatives in the plan, and these are described after we outlined a number of the public health problems that needed to be addressed and have developed, as you have pointed out in your opening statement, beginning on page 6 and subsequent to that.

We believe that the public health measures are integral to achieving the goals of reform, not supplemental to it. The President's plan is the only one that offers an integrated approach that includes public health infrastructure as well as reforms in the personal health care system.

We have three objectives in this initiative. First, strengthening the capability of communities to protect the health of their populations and address high priority local health problems. Second, im-

proving the knowledge base for preventing disease and providing care more appropriately and efficiently. Third, assuring access to necessary health services for all Americans, particularly low income, isolated, hard to reach populations. That latter issue was addressed at the earlier hearings.

Under title III we have two basic approaches, the core public health program, a competitive grant program to provide funds to State health agencies to strengthen essential public health functions, and these are outlined in the testimony.

First, surveillance in communicable and chronic disease control. Here we are talking about things like tuberculosis. We are talking about outbreaks of salmonella which can be linked to specific sources of infection. We would be dealing with things like tracking emerging problems that might be related to environmental health issues, such as toxic exposures in the environment or in the workplace.

Second, control of communicable diseases and injuries, and these functions, again, would deal with such diseases as tuberculosis. To prevent the spread of tuberculosis in the community, you need effective treatment for everybody who is infected. For some, particularly those with drug resistant tuberculosis, you need to have observed treatment.

For sexually transmitted diseases, there are effective interventions, not only treatment, contact tracing, partner notification, in order that the spread can be effectively curtailed.

There need to be interventions with respect to food and water-borne diseases. So a number of the basics would be covered under that provision.

Third, environmental protection. Food, water, workplace, housing, essential there to provide protections, and again, lead poisoning would be an example of if you find a youngster with lead poisoning in a health plan, it is the health department that then traces the source of the lead, initiates abatement procedures, and effectively prevents subsequent lead poisoning in the population.

A very important element in the core public health functions are public education and community mobilization, and here we are looking at problems that are not related to personal medical care or can be more effectively dealt with through these community-wide interventions.

If we look at what has happened with the reductions in mortality from heart disease, the interventions with respect to cigarette smoking and the community interventions, including those activities that have protected non-smokers' rights, the health of individuals who have been in the past exposed to secondhand smoke, would be examples of this kind of community intervention.

Important core function is included accountability and quality assurance which are essential to enhancing the State function for certification of health professionals and licensing of facilities to protect consumers from medical and health services. We are concerned about the plans as accountable plans and the role of States in assuring that plans perform effectively through measuring their performance.

Public health laboratories also are an essential function. We saw the importance of this in the Hanta virus epidemic. The labora-

tories for the Centers for Disease Control and Prevention rapidly identified the source of that infection and we were able to move effectively in that regard. Finally, training and education of public health professionals is an essential element. The second, in addition to the core public health functions, would be initiatives that were linked to national initiatives, but these would be locally determined and the funds could go to public or nonprofit agencies to develop community-based prevention programs to address issues that are particularly important in a given community.

In one community it might be adolescent cigarette smoking. In another it might be violence prevention. In another, it might be a program for chronic disease control.

Another element in the plan is an expansion of research, both at the National Institutes of Health for Prevention Research and in the agency for Health Care Policy and Research to expand our knowledge for improving the effectiveness of care and improving outcomes of care.

Let me then turn to the consumer protection issues, and these are addressed beginning on page 19 in the statement. Consumer protection is at the heart of the Health Security Act. For the first time, consumers will be guaranteed security of insurance coverage at a fair price and with choices of plans that meet individual and family needs.

To assist consumers in making wise choices among competing health plans, the alliances will provide a user friendly report card detailing the performance of health plans among various measures of quality and consumer satisfaction.

The alliances will be governed by boards with 50 percent consumer membership. There will be an ombudsman office at the alliance level. Consumer grievances have been dealt with, and I think that the provisions in the bill really provide consumers an adequate means to address grievances. These are detailed in the bill, but I would just say basically there is a general standard of medically necessary and appropriate care for determination of which medical services are covered beyond the detailed listing specified in the bill.

Disputes inevitably will arise concerning individual claims that a service should have been provided or paid for when a health plan asserts that the service is not part of the comprehensive benefit package. For those situations, the President's bill establishes an efficient and fair grievance resolution system which I detail in the testimony.

Finally, consumers are provided access to information regarding physicians who have been sanctioned and this is data that is currently provided in the national practitioner data bank.

Critically important, as you have pointed out with respect to the Health Security Card and the plan, are privacy protections for individuals and for their records, and again the three principles that I have described in the statement which would underlie, we think, these protections in the act.

First, any disclosure permitted by law shall be of the minimum amount of information necessary to achieve the lawful purposes of that disclosure. Second, that every patient shall have a right to know in what locations any individually identifiable information is

maintained and the purposes for which such information could be disclosed.

And finally, that every patient shall have a right to access to individually identified information in order to see, copy or correct such records, and I should say that these are really critical because the current system does not afford adequate privacy protections for many individuals.

In the law, the board—or in the act, the board is directed to prepare for the President and Congress a detailed proposal for comprehensive medical records legislation and with regard to the Health Security Card, the act will prohibit any use of the card except for purposes of obtaining the items and services in the guaranteed national benefit package.

Anyone who requires a display or use of the card or requires the disclosure or use of the unique identifying number for any other purpose will be subject to criminal penalties.

That in brief, Mr. Chairman, concludes my statement and Nan Hunter and I will be pleased to respond to any questions.

Mr. WAXMAN. Thank you very much, Mr. Lee.

[Testimony resumes on p. 354.]

[The prepared statement of Dr. Lee follows:]

STATEMENT OF

PHILIP R. LEE, M.D.

ASSISTANT SECRETARY FOR HEALTH

Mr. Chairman and Members of the Subcommittee:

I welcome this opportunity to discuss several important features of the President's Health Security Act --the public health initiatives and provisions for quality assurance and consumer protection. Accompanying me today is Nan Hunter, Deputy General Council of Health and Human Services, who is prepared to answer questions on the latter topic.

This morning, I urge the Subcommittee first to shift its attention to an important, but not well acknowledged, element of the President's plan -- the reform of our public health system. Under the Health Security Act, we will do far more than just treat people when they are sick. We will achieve the two fundamental goals set of our Nation's health promotion and disease prevention agenda:

- improve the health of Americans; and
- reduce health disparities among Americans.

The Health Security Act calls for increased investment in public health. If we follow this course, people will suffer fewer illnesses and injuries and the government, health care providers, businesses and individuals will avoid considerable health care costs.

THE NEW HEALTH-ORIENTED FRAMEWORK OF REFORM

The President's plan has a new health-oriented approach that emphasizes personal accountability, disease prevention, and a close working relationship between the personal care and public health systems.

Central to this approach is a restructuring of the personal health care system, enabling it -- for the first time -- to focus on keeping people healthy.

All Americans will have comprehensive benefits including clinical preventive services without deductibles or copayments. Regional alliances and health plans will be responsible for making sure that their populations have access to these covered services. Report cards on each health plan will focus plan's attention on achieving healthy outcomes for their members and will allow their members to monitor how well they will accomplish their goals.

The financing and payment system will reward alliances and health plans for keeping their populations well. Health plans will receive a fixed annual premium to cover total patient care. To the extent their enrollees are kept healthy, plan health care costs will be lower and premiums paid by individuals and employers will be lower.

Mr. Chairman, these changes in the personal health care system mean that health plans will focus on keeping people healthy. In doing so, health plans and alliances will work closely with public health agencies. These changes in the personal health care system also make it possible to refocus the public health system on protecting and promoting the health of our communities.

In recent years, as the private health insurance system failed more and more working Americans, State, and local public health agencies became increasingly involved in providing personal medical care and mental health services to the poor and uninsured. In an environment of limited resources, this shift in public health spending toward personal medical care was at the expense of public health programs designed to keep communities healthy. This steady erosion led the Institute of Medicine in 1989 to declare the public health system to be "in disarray" and a "threat to the health of the public." The American Public Health Association, in its recent report "Public Health in Reformed Health Care System: A Vision for the Future" reiterated these problems. We have confirmed them in our own analyses during the past nine months.

When public health fails, people and communities suffer and personal health care costs increase. Let me give you a few examples.

- Every year, an estimated 900,000 people fall ill -- and 900 die -- from contaminated drinking water. In Wisconsin alone, a failure to protect the quality of drinking water, and to detect and control Cryptosporidium, caused over 370,000 people to fall ill -- 4,000 of whom required hospitalization -- and led to over \$15 million in medical care costs.
- State public health staff report that they have had to severely curtail or even close down restaurant inspection efforts due to a lack of funds, despite the fact that in 1991 and 1992, 212 cases of Hepatitis A in Missouri, Wisconsin, and Alaska were traced to infected restaurant workers. In 1987, Hepatitis A outbreaks infected 75,000 Americans, at a cost of \$766 million.
- An outbreak of E. coli linked to a restaurant chain last year resulted in 500 laboratory-verified cases of bloody diarrhea in Washington State, Idaho, California, and Nevada. The costs of treatment were \$100-\$200 for every case not requiring hospitalizations and much more for those young children and frail elderly who had to be hospitalized.

- Hepatitis B infects up to 300,000 people each year in the United States, at a cost of \$750 million per year, despite the fact that a vaccine to prevent the disease has been available for the past decade. Yet only one percent of the estimated 28 million young adults at risk for hepatitis B have received it.

- Substance abuse is not only an epidemic in and of itself; it is also at the root of other public health problems. Substance abusers are the fastest growing segment of the HIV/AIDS population, and substance abusers with AIDS are a major factor in the spread of multi-drug resistant tuberculosis. Fifteen percent of women delivering babies in Harlem Hospital use cocaine. According to the Center on Addiction and Substance Abuse at Columbia University, substance abuse is currently estimated to add \$140 billion to our country's direct and indirect health care costs every year, including \$500 million to treat cocaine-affected infants during their first month of life.

I can't emphasize enough that we now have an historic opportunity to improve the health of the American people. If we reform the personal care system as the President has proposed, the public health system will no longer need to provide covered services to indigent and uninsured populations. Instead, public

health agencies can turn their resources and expertise back to their original role of protecting the health of communities and removing barriers to medical care.

By working closely with alliances and health plans, public health agencies can be far more effective in achieving community-wide improvements in health. For example, they can work through alliances and health plans to inform and educate individual patients and providers. And they can reinforce the efforts of alliances and health plans by protecting communities against environmental hazards, identifying and controlling community outbreaks of infectious diseases, and instituting community-wide education programs.

Reforming the public health system is not supplemental to health care reform. It is an integral part of achieving the goals of reform. The programs outlined in Title III of the Health Security Act are the means by which the President proposes to strengthen and refocus the public health system. The success of these programs will ultimately determine how well health security is provided for all Americans and how well health disparities among Americans are reduced or eliminated. They will also play a vital role in determining the extent to which we will be able to contain accelerating health care costs.

**SPECIFIC PUBLIC HEALTH INITIATIVE
IN THE HEALTH SECURITY ACT**

The programs in the Public Health Initiative

- strengthen the capability of communities to protect the health of their populations and address high-priority local health problems;
- improve the knowledge base for preventing disease and providing medical care more appropriately and efficiently; and
- assure access to necessary health services for all Americans, particularly low-income, isolated, hard-to-reach populations.

The third of these has been the subject of your earlier hearing, so I will focus today on the first two.

Improving the Health of Communities:

Core Public Health and Prevention Initiatives

The President's health care reform plan can meet its cost-containment targets and address pressing health problems -- such as

teenage pregnancy, lead poisoning, diabetes, tobacco and drug abuse, and violence -- because it strengthens our capacity to provide population-based public health activities. To succeed, we must define the population groups for whom particular problems are most common. We must learn why some communities are hard-hit by a problem while others somehow seem to escape. To use limited resources most efficiently, we must target public health education and prevention interventions to populations at highest risk and populations with different cultural backgrounds. And, to address our most intractable health problems, we must create linkages among public health agencies, health plans, and health care providers.

Two programs included in Title III strengthen and refocus our population-based public health activities. These two grant programs will be implemented through the nation's prevention agency, the Centers for Disease Control and Prevention (CDC). This approach will take advantage of CDC's ongoing efforts to strengthen population-based public health strategies and make prevention a cornerstone of public and private health programs.

- **Core Public Health Program:** This competitive grant program will provide funds to State health agencies to strengthen the following essential public health functions at state and local levels:

(1) surveillance of communicable and chronic diseases -- essential to define the magnitude, source, and trends of health problems so that limited resources can be directed to populations at greatest risk and health outcomes can be tracked as the final measurement of quality. This is the public health function that provides timely identification of patterns of disease, such as an outbreak of salmonellosis that can be linked to a specific source of infection, emerging diseases such as Hantavirus requiring fast-track research, or toxic exposure-related incidence of cancer calling for environmental intervention.

(2) control of communicable diseases and injuries -- essential to ensure that new problems are identified early, that contact tracing and partner notification occur effectively, and that sources of infectious exposures are removed. This function is essential to contain the spread of tuberculosis, sexually transmitted diseases, and HIV infection, as well as well as waterborne and foodborne diseases that spread from single sources to infect large numbers of people.

(3) environmental protection -- essential to safeguard the physical and social environment (e.g., water, food, workplace, housing) against causes of disease. This

public health function is virtually invisible to the public as long as it is working effectively, but it is essential to our quality of life, allowing us to enjoy a level of physical safety from infection and exposure that has never been known before this half of this century.

(4) public education and community mobilization -- essential to prevent major causes of premature death and disability that are behavioral and societal in nature. This function proves its utility through changes in smoking, diet, and safety measures brought about because people are informed and motivated to change their own health-related behavior, resulting in a 25 percent reduction in heart disease deaths within the past decade, over a 50 percent reduction in stroke deaths over the past 25 years, and perceptible changes in unhealthy patterns that were unquestioned only a generation ago.

(5) accountability and quality assurance -- essential to enhancing the state function of certification of health professionals and licensing of facilities to protect consumers from medical and health services, whose interactions with their clients and consumers can be a source of illness or health. We foresee public health's ability to measure health outcomes through its surveillance function also equipping it to play a central

role in assuring the quality of health plans by providing input to their report cards.

(6) public laboratory services -- essential in the diagnosis of major infectious and environmental threats to health. This public health function measures everything from ambient asbestos in schools, to blood alcohol levels in impaired drivers, to emerging diseases whose source and mode of infection must be quickly identified.

(7) training and education of public health professionals -- essential to ensure a workforce capable of carrying out public health functions.

Enhancing the Core Public Health program fosters greater accountability for public funds supporting these functions by requiring progress reports on achievement of clearly defined public health objectives.

- **National Prevention Initiatives Program:** A second competitive grant program will provide funds to public and private not-for-profit agencies to develop community-based prevention programs to address health issues that affect local communities or specific populations within communities. Many of these problems do not affect the

country uniformly and call for tailored interventions. In addition, they can often best be addressed by community organizations working to define effective interventions that best meet the community's own needs, values, and culture.

Among the health issues that we foresee getting initial attention under this program are: prevention of violence, especially in inner cities; smoking initiation, especially among young women whose rates of smoking appear to be going up; and prevention of chronic diseases that are affected by behavioral patterns such as diet, physical activity, and smoking and affect some minority populations at much higher rates than those experienced by the general population. For each initiative, the key will be to call for community-based interventions rather than to prescribe interventions from the Federal level; but in each initiative projects will be called upon to set and attain measurable improvements in the health status of the populations which they address.

Once again, while these initiatives are valuable in themselves, they also perform a critical role in helping to reduce demand for preventable, costly medical programs.

Improving our Knowledge Base:**Prevention and Health Services Research**

The Public Health Initiative also includes new prevention research in the National Institutes of Health and expanded health services research in the Agency for Health Care Policy and Research. These research efforts will expand the knowledge base needed to prevent disease and promote health more effectively. They will develop the information that will improve the quality of health care, facilitate access, and contribute to containing the rising costs of health care.

Prevention research is the foundation for both clinical preventive services targeted to individuals and population based public health interventions included in the Health Security Act. Expanded prevention research will enhance the availability of effective preventive measures against existing diseases as well as new and emerging health threats. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly. Among the top priorities that still pose prevention challenges are HIV infection and Alzheimer's Disease, two examples that cause extremely heavy human and financial burdens.

Health services research will provide the information we need to improve the quality of medical care, organize providers in new cost effective systems, and help consumers make wise choices about their providers and health plans. The new investment envisioned in the Health Security Act will:

-- expand outcomes and quality research (so that health plan report cards can be realized 3-5 years after enactment);

--study practice variations with unnecessarily high costs (to decrease variation in practice while improving quality of care); and

--synthesize information on the appropriateness and effectiveness of care into practice guidelines in order to improve treatment decisions made by health professionals.

Other research will develop methods to evaluate the success of health reform in achieving its goals: assess the performance of alliances and health plans, improve risk adjustment, assess the extent to which reform is making health care available to all Americans, analyze the factors that contribute to rising costs, and develop measures of quality to be used in the plan report cards.

IMPROVING THE QUALITY OF CARE

Improving the quality of care is one of the most important goals of the Health Security Act. Most consumers have great faith in their physicians, hospitals and other medical care providers, and are generally satisfied with the medical care that they receive. Many Americans have access to the most advanced and sophisticated medical procedures and technology in the world. However, medical practice varies enormously by region of the country without an accompanying variation in the severity of patient illnesses or in the health outcomes achieved.

The last ten years of quality of care research has begun to identify what works best in medicine and much experience has been gained in developing guidelines to help physicians improve their practices and enable patients to make better use of the medical care system. In the same ten years the health system has begun a fundamental organizational shift away from individual fee-for-service practice to capitated managed care. This has heightened the interest in developing quality measures for "systems" of care and for more rapid assessment of medical effectiveness. The increased competition between managed care and the traditional indemnity insurance also has broadened the definition of quality to include measures of access and consumer satisfaction.

As we move forward with reform, the focus of the quality system will shift from the bureaucratic, retrospective, case-by-case review of specific encounters and procedures to accountability of health plans and providers based on measures of performance and outcomes. Plans with the responsibility for the long term health of their populations will have increased incentives to practice cost effective medicine including maximum use of prevention and early detection of diseases.

The Health Security Act will assure and improve the quality of care in six ways:

1. National quality measures will be established. The National Health Board and its private sector quality council will be responsible for developing a set of national quality goals and measurements of performance for health plans. Each plan would be responsible for collecting this information which would include:

- consumer ease of access- such as waiting time
- appropriateness of care- such as rates of surgery
- outcomes of care- such as survival rates
- health promotion and prevention- immunization rates
- consumer satisfaction from surveys

2. Plans will be required to publish annual "quality report cards" that will allow consumers to compare the performance of each health plan within their alliance and choose their health plan based on these uniform quality measures and the premium cost. The report card will be presented in a standard format and alliances will be required to disseminate this information to consumers in a user-friendly fashion. Quality report cards empower consumers to judge quality improvement, and are being used today by several organizations including United Health Care, US Healthcare and Kaiser Permanente.

3. The Agency for Health Care Policy and Research will expand outcomes research and increase the development of clinical practice guidelines. Outcomes research is the scientific assessment of what works and what doesn't work in medicine and the numerous factors affecting effectiveness. Clinical practice guidelines facilitate the accurate translation of medical and outcomes research into readily useable decision-making tools for clinicians and patients. The expansion of these "tools" for improving the quality of care includes the establishment of a clearinghouse and certification of guidelines developed by the private sector and a dissemination program to be utilized by Regional Professional Foundations.

4. Regional Professional Foundations composed of Academic Health Centers, Schools of Public Health, Plans and Providers

will be at the center of continuing education of health professionals and dissemination of information to those who need it. These private sector organizations will develop lifetime learning programs for health professionals, disseminate clinical practice guidelines and information on "best practices", foster collaboration among plans and providers, and develop innovative patient education systems to enhance patients' involvement in decisions about their health care.

5. States will establish quality criteria and certify health plans based on the criteria. Plans will also be required to meet a series of consumer protections including : fiscal soundness, truth in marketing, grievance procedures, disclosure of consumer rights and responsibilities, disenrollment only for cause, and disclosure of utilization management practices.

6. Administrative simplification will reduce paperwork for providers and allow more time for continuous quality improvement. These measures include relieving simple physician laboratories from registration under the Clinical Laboratories Improvement Act (CLIA), standardizing claims forms, electronic claims transmission, and the development of uniform standards for licensing health care institutions.

Through these six steps the Health Security Act will transform a patchwork of process measures, regulatory procedures, and uneven quality into a uniform national quality management system focused on performance measures and continuing quality improvement. The further integration of public health with the personal health care system will afford new opportunities for health plans and providers to practice prevention and to focus quality measures on the outcomes of care in populations. We believe this will ensure that the health care delivered under the President's plan will meet the high standards that Americans have come to expect.

CONSUMER PROTECTION

Consumer protection is the heart of the Health Security Act. For the first time, consumers will be guaranteed security of insurance coverage, at a fair price, and with choices of plans that meet individual and family needs. To assist consumers in making wise choices among competing health plans, the alliances will provide a user-friendly report card detailing the performance of health plans along various measures of quality and consumer satisfaction.

Further, the alliances will be governed by Boards with a fifty percent consumer membership. They will serve a watchdog function to ensure that health plans are serving all consumers in the area, that plans are truthfully marketed and that consumer rights and

responsibilities are fully disclosed. Ombudsman Offices at the alliance level will further serve to both educate consumers and to be an advocate to help resolve grievances in a fair and timely manner. Also, consumers will receive better care through administrative simplification, tort reform, improvements on clinical practice guidelines and quality measurement. Through these means, the Health Security Act will give consumers the knowledge and power to obtain high quality health care at an affordable price.

Consumer Grievances

The President's bill establishes the general standard of "medically necessary or appropriate" for the determination of which medical services are covered, beyond the detailed listing specified in the bill itself. Disputes inevitably will arise concerning individual claims that a service should have been provided or paid for, when a health plan is asserting that the service is not part of the comprehensive benefit package. For those situations, the President's bill establishes an efficient and fair grievance resolution system.

The Act provides a comprehensive system of administrative and judicial review to ensure fair, accessible, and expeditious determinations of rights and benefits. Section 1326 accordingly requires each regional alliance to establish an "office of

ombudsman" to assist consumers in dealing with problems that arise with health plans and the alliance, and to ensure that enrollees understand their rights and remedies under the Act. In addition, the Act sets forth specific rights and remedies for establishing entitlement to coverage or reimbursement. The Act provides that a health plan must act on a claim quickly and provide clear, easily understandable notice of its decision. Most claims must thus be resolved within 30 days, and requests for preauthorization of certain urgently-needed services must be resolved within 24 hours.

If the health plan denies a claim, the provider or enrolled individual can elect one of several different means of appeal and redress. First, a claimant can challenge a health plan's denial of coverage or reimbursement by appealing to administrative review bodies created by the Act. Both corporate and regional alliance claimants must use these procedures. Under these review procedures, a claimant has the right to present evidence and testimony in support of his or her claim at a hearing before an impartial hearing officer who may affirm the health plan's denial of coverage or order the claim paid. The hearing officer's decision may then, upon the request of any party to the hearing, be reviewed by the Federal Health Plan Review Board, a five-member administrative panel of specially qualified individuals appointed by the Secretary of Labor. The Review Board determines whether the hearing officer's decision is adequately supported by the administrative record and consistent with applicable law. A

claimant or health plan that is dissatisfied with the Review Board's final order may then seek review in the United States courts of appeals, provided the amount or value in dispute exceeds \$10,000.

A claimant may also elect two alternative means of redress. He or she may, without losing any other right to administrative and judicial review, seek non-binding mediation of the dispute. In addition, claimants who participate in a regional alliance may forgo the administrative and mediation remedies established by the Act and seek relief in court.

Access to Information About Providers

One of the improvements for consumers in the President's plan is its opening of access by consumers to information about physicians who have been sanctioned. The Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of physicians who have a pattern of malpractice payouts or sanctions. As this committee is aware, under the Health Care Quality Improvement Act, malpractice payouts and sanctions are reported to the National Practitioner Data Bank, and that information is made available to states or accrediting bodies, but not to the general public. Under the Health Security Act, for the first time, the names of health care practitioners with repeated numbers of sanctions will be available to the public.

With this information and the information available through the quality measures in the proposal, the public can make more informed choices about the physicians they choose, and thus improve the quality of the health care they receive.

PROTECTING PRIVACY OF PATIENT RECORDS

The Act directs the National Health Board to promulgate standards to protect the privacy of individually identifiable information which is collected and/or reported as part of the new system. Those standards will be based on several core principles established by the legislation, including the following:

- * that any disclosures permitted by law shall be of the minimum amount of information necessary to achieve the lawful purpose of that disclosure
- * that every patient shall have a right to know in what locations any individually identifiable information is maintained and the purposes for which such information could be disclosed, and
- * that every patient shall have a right of access to individually identifiable information in order to see, copy or correct such records.

In addition, the Board is directed to prepare for the President and for Congress and detailed proposal for comprehensive medical records legislation.

With regard to the health security card, the Act will prohibit any use of the card except for the purposes of obtaining the items and services in the guaranteed national benefit package. Anyone who requires the display or use of the card, or who requires the disclosure or use of the unique identifier number, for any other purpose will be subject to criminal penalties.

Mr. Chairman, this concludes my statement. I would be pleased to answer the questions you, or other Members of the Committee, may have.

Mr. WAXMAN. In your testimony, you discussed a number of measures in the President's plan that are expansions of public health programs now authorized by the Public Health Service Act.

For example, you have said you want to help the States and local governments with epidemiology and disease surveillance to help control TB and STD's and to ensure environmental health. But as we discussed at last week's hearing on essential community providers, the bill doesn't provide enough money for these public health initiatives. It simply authorizes them without any reliable funding for them, and since the budget bill last year froze all appropriations for 5 years, there is not much chance of getting the money for these programs without cutting other programs, and we are all afraid that it might mean robbing Peter to pay Paul.

The administration found mandatory money, a guaranteed funding stream for a number of other programs in this bill, but not for these. How can you say—how can you lay out such a high ambition for these programs without providing money? Aren't you just saying that these programs will get whatever is left over?

Mr. LEE. Well, if we do not provide for the assured source of funding, that would certainly be the case. The administration is committed to working with the Congress to identify an assured source of funding to support the initiatives in title III, and hopefully that will progress rapidly.

I know this committee has a deep concern about that and I can assure you that we will do everything possible to expedite that process to identify the source of funding and to work with the Congress to assure that source of funding.

Mr. WAXMAN. We are going to start markup presumably in 3 weeks. The administration has been working on it for more than a year. When are you going to have a final position on funding these initiatives? Would you please have this information available to us within the next several weeks?

Mr. LEE. I would certainly hope so, Mr. Chairman.

Mr. WAXMAN. The public health initiatives you propose in your bill are very broad and sometimes amorphous. Every State is doing something that can now at least be labeled a core public health initiative and most States are cash strapped now.

As this morning's Washington Post makes clear, many States are looking for creative ways to refinance their efforts using Federal money to pay for what State money now provides. How are you going to assure that States maintain their ongoing efforts and that the Federal money in these programs actually buys new services and doesn't just shift the financing for existing services to the Federal Government?

Mr. LEE. Well, we need to have a very clear maintenance of effort provision and if it is the feeling of this committee that those provisions are not sufficient, we would certainly work with you to make them sufficient to assure that States would continue and local governments would continue their current maintenance of effort.

I was in Los Angeles County on Thursday and Friday working with and reviewing with the local public health officials the current state of public health, particularly in response to the earthquake

emergency. The highest priority need right now is for the surveillance function to monitor the community.

They have been doing surveys in homes to see who had safe water supplies, who did not have, who had adequate sanitary facilities available. They are making a very substantial investment from local tax funds, and I think we need to have the maintenance of effort requirements in order that we can strengthen those with this core public health provision.

Mr. WAXMAN. If we are going to try to make sure the States are doing what we expect of them, will you support establishing standards for measuring State progress in achieving the goals of Healthy People 2000 report, and can we hold States accountable for the use of funds in this manner?

Mr. LEE. First of all, we definitely need to hold the States accountable. I think many States will set specific Healthy People 2000 objectives as the objectives to be achieved through funding of the core public health activities. Some States might pick a different public health objective, but they will be identified, specified, and they will be held accountable.

I think that is absolutely critical if we are to have an accountable program through the core public health function.

Mr. WAXMAN. You observe in your testimony disputes will be inevitable between health plans and consumers as to whether a particular service is medically necessary or appropriate and therefore covered.

The way the President's bill proposes to deal with these disputes is a grievance resolution system, including ombudsman and administrative and judicial review of claims denials.

As we will hear later today, consumer representatives do not believe that this grievance resolution system is adequate. Obviously if we are going to go down the managed competition road, as the President proposes, then we must assure that claims disputes between health plans and consumers are promptly, efficiently, and fairly resolved because I am equally concerned about how likely it is that these claims denials occur in the first place, and that is a function of how much pressure the physicians and other providers in the plans are under not to deliver care.

We have a long and sorry history of outrageous physician incentive arrangements in Medicare and Medicaid. That is why the Congress several years ago expressly prohibited any health plan contracting with Medicare and Medicaid from placing physicians at substantial financial risk for hospital or other services without adequate protections.

My question is, why doesn't the President's bill apply this same standard to health plans offered by the alliances? Why does the bill in effect give the plans complete flexibility to establish financial incentive arrangements with their physicians that strongly reward the denial of care, and wouldn't it make sense to prohibit plans from establishing physician incentive arrangements that will lead to many denials of care overwhelming the grievance resolution process and enriching the plans and their attorneys?

Mr. LEE. We would agree, Mr. Chairman, and we would be glad to work with you and members of this committee to achieve a proper set of standards in the legislation. As you have pointed out, the

Health Security Act does not explicitly extend the Medicare and Medicaid standards for physician incentive arrangements, and these would be a model that we might then apply. We would certainly be glad to work with you on that, because that is an issue we are as—we certainly do not want to have incentives that do not assure people appropriate levels of care. As there are concerns about this, we think those concerns need to be specifically addressed.

Mr. WAXMAN. I have other questions, but I want to recognize Mr. Cooper for his opportunity to ask questions. Then I will come back on the next round.

Mr. Cooper.

Mr. COOPER. I thank the chairman. I will be very brief. I want to congratulate the Chair for his long leadership in public health areas. It is with some sadness I think we all acknowledge that today's health care system in America, while it has many virtuous, has not done as much in the public health area as it should have.

We have shortchanged preventive care, primary care, prehospital care, a number of these areas. I have been made particularly sensitive to these needs by my own mother-in-law who has worked as an M.D. in Mississippi public health care for probably more years than I should tell you publicly, did a great job trying to keep up with the different problems that have plagued not only that area but many other parts of the country for a long, long time.

I think it is one of the most exciting parts of the prospect of national health care reform. We will finally be able to get everyone pulling together working toward an improved public health system. So I look forward to working with the Chair and other Members to make sure that this can become a reality this year.

I thank the Chair.

Mr. LEE. If I might just make a comment on that too, Mr. Chairman. We believe that the health plans, with the incentives for capitated payments, will have far greater incentives for achieving population-based public health objectives. Immunization is a good example of that, and that is one of the reasons that the approach the President proposed is so exciting.

It permits a real partnership between health plans and public health in a way that, in the current system, is not possible. We do not have an accountable system. There are no incentives to provide preventive services or to achieve population-based public health objectives, and to me that is one of the most exciting parts of the plan.

Mr. WAXMAN. Well, if you think that will be accomplished through the plan's desiring to provide Public Health Services presumably because they want to keep the population healthier, do you see any reason why we ought to continue the public health programs that we fund at the Federal level? Should we let the plans go ahead and take on those responsibilities themselves?

Mr. LEE. We absolutely have to continue the Federal public health programs. Without those, we don't have any assurance until we have fully implemented the Act. We intend to request reauthorization of all the categorical programs that we are currently funding because in many cases you need to assure an infrastructure of public health to achieve the objectives, also, you have to have tar-

geted efforts, like the HIV prevention programs or TB control programs.

It is essential that we continue these programs even though we believe that we will have significant improvements in public health through the plans. There are certain public health functions that must be and will be performed by public health departments if we are to protect the health of all of us. Particularly if we are to protect the health of the most vulnerable population, because they are exposed to greater risk from things like tuberculosis.

Mr. WAXMAN. Well, tell us what kinds of things we could look to the plans to take over in the area of public health in a managed competition system.

Mr. LEE. Well, I would think, for example, immunization is one such area. It is a personally delivered service, but first, there needs to be accountability.

We need to measure the performance of the plans—do they immunize the kids as the goals set forth. Then we need to have data, community based health statistics on morbidity and mortality so we can measure performance not only on process, were the kids appropriately immunized, but was there any preventable infectious disease in the community, that the plan should have addressed and one of the objectives should be identified for the plan and then examined—were they achieved, were they not achieved? Plan performance then gets evaluated on that basis.

Mr. WAXMAN. Would you reevaluate a plan on the basis of what is happening in the community or only for those members that are part of that plan?

Mr. LEE. There are three levels. One is the plan performance with respect to the population for which it has responsibility. Second, the alliance performance, because that is again a population-based approach, and third is the performance of the public health agency at the State and local level to achieve the public health objectives.

So I think we have opportunities at those three levels to evaluate performance in achieving public health objectives.

Mr. WAXMAN. Well, give me another example.

Mr. LEE. Another example would be screening, for example, Pap smears of women to early detect cervical cancer and treat it early, or mammography of women over 50. The director of the National Cancer Institute, Dr. Sam Broder, has indicated if we were doing mammographies now appropriately for women over 50, we could significantly reduce the morbidity and mortality from breast cancer, and that is particularly true in lower income and minority populations.

That would be another area where we could assess the performance of the plan. Did they do the mammographies, and then what was the result in terms of the prevention of, let's say, early mortality from breast cancer. You can look at hypertension as another example.

Mr. WAXMAN. How do you evaluate whether a plan has done an adequate job in screening?

Mr. LEE. You set certain goals with respect to mammography for women over 50. You measure whether the plan in fact achieved those goals, what was then the rate of early detection of breast can-

cer, and then whether treatments were given to those women early enough to reduce their subsequent mortality from breast cancer.

Mr. WAXMAN. Who will set those goals, the plan or some other agency?

Mr. LEE. Well, I believe that we should have public health goals as one of the goals that is set for the plans by the State. In other words, the State should say that health plans have to achieve certain public health goals, just as in our core public health we would say that the State has to achieve, and we would agree on what the goals they would be achieving.

Within that State, it seems to me the State then has to say to the plans, here are certain goals that can be achievable by the health plans.

Mr. WAXMAN. Who will monitor the health plans to see if they are achieving these goals?

Mr. LEE. I think the alliance would monitor the health plans, but particularly the public health agencies and particularly at the State level, would have a responsibility to monitor, to see if we are achieving the public health objectives.

The consumers would also monitor because they will receive a quality report card so that—and that is one of the—to me one of the valuable parts again of the plan. That will be information about public health objectives, did they achieve. I mean, prenatal care, immunization, mammography, other public health objectives could be identified.

That information provided to the consumers and if they find that a plan is not providing prenatal care or is not doing the immunizations as well as another plan, they can then choose a plan based on those performance measures, and that is of course a critical part of the consumer choice.

To me, the most important part of these competing plans is competition on the basis of quality and an affordable price, but quality is an absolutely essential element in the whole plan.

Mr. WAXMAN. Now, let's say the public health agency has determined that a plan is not living up to these standards. What happens then?

Mr. LEE. There are two things. One, you are informing the consumers and the consumers may talk with their feet, or you can have, as an accreditation measure for a plan, a certain level of performance has to be achieved and if it doesn't achieve that, the plan then is not participating.

Mr. WAXMAN. Who is going to credit these plans, who is going to reevaluate them based on the information they are not living up to their goals?

Mr. LEE. States will do that, but they don't do that now on a performance basis. You have examples such as in California, the Knox-Keene provision and there are various provisions that relate to financial soundness of the plan.

There are no performance measures currently required of plans to achieve public health objectives.

Mr. WAXMAN. Does the administration's bill put one in place so that we can make sure that these plans are accredited because they are meeting the standards that we expect of them, or are we

simply going to rely on consumers to leave if they find out that they have not been given the care?

Mr. LEE. It is very specific with respect to the report card and what can be in the report card. In terms of the State requirements for plans, a quality requirement would be there, but we can work to clarify that more fully.

Again, I think we can discuss with this committee what should be the requirements for plan performance in the legislation.

Mr. WAXMAN. Now, if a consumer is unhappy with what is going on in his plan, her plan, that the plan is saying, no, we are not going to cover certain services and that is just the way it is, the President's proposal says that the people can, if they are in a regional alliance, avail themselves of certain administrative remedies, but if they are in a corporate alliance, they wouldn't be able to have those same remedies.

It seems to me that in many areas the same plan will be serving both a regional and corporate alliance, yet plan members will not have the same assurances of quality and remedies. That doesn't make sense. Why do we have that distinction?

Mr. LEE. Nan, do you want to answer?

Ms. HUNTER. Yes, if I might, Mr. Chairman. The structure for grievance procedures is somewhat different for individuals in corporate alliances and in regional alliances. The reason for that was that the decision was made to attempt to track to some extent existing ERISA remedies which cover people who are now in self-insured plans, so the structure of grievance procedures to some extent follows that difference.

However, the remedies in the Health Security Act provide in some ways more than the current ERISA system does. Under ERISA, current remedies are quite limited to recovery of specific benefit amounts, and in the administrative—

Mr. WAXMAN. Why do we care about ERISA anymore if we are establishing a health security program for the country and we are saying the people are going to be in these alliances, and if they are in the alliances, they get certain consumer protections, but if they happen to stay—if they are outside the alliance because they are exempted due to the fact they are in a corporate alliance, they don't have those protections.

Secretary Bentsen was quoted in the paper as saying he is open to negotiating these alliances and maybe having lots of different groups going on to represent smaller portions of the population.

Are we going to have different consumer protections for some people and no consumer protections for other people? How are we going to fill in this area so that we give the consumer the best chance to make sure he or she gets what they are supposed to get.

Ms. HUNTER. Let me just emphasize that the only distinction is in the fact that for persons in corporate alliances the administrative process is the exclusive remedy. So persons in corporate alliances have the full array of other consumer protections, including those that are built into the system design that Dr. Lee was talking about in terms of information and the power to be able to select among plans.

Mr. WAXMAN. Well, you selected a plan. You have been given your choice of plans, you selected a plan. You go to the plan and

you say, now, I am sick. I wasn't sick when I selected you, but the reason I selected this plan is because I want to be taken care of, and this gate keeper doctor is saying that I shouldn't have a certain test and I think I ought to have that test, and the President says, well, if I purchased membership in this plan through the alliance, I have certain ways I can appeal that, but if I am not in that alliance and I am in some other alliance, I won't have those protections.

What do I do then?

Ms. HUNTER. Let me just emphasize that a person in a corporate alliance has the full range of remedies that are in the administrative process.

Mr. WAXMAN. Tell us what they are.

Ms. HUNTER. Those include going through, if the person chooses, a mediation process or going immediately into an administrative hearing before a State administrative law judge. That State administrative law judge has the obligation to reconsider anew whatever denial or delay in benefits occurred that led to the grievance, and then there is a right of appeal from the decision of the State administrative law judge to a Federal health board review agency that reconsiders the decision. If the amount in question is substantial, if it is greater than \$10,000, then there is a further right of appeal out of the administrative process into a United States Court of Appeals.

Mr. WAXMAN. So everybody has the opportunity to do this.

Ms. HUNTER. Everyone has an opportunity.

Mr. WAXMAN. Assuming they can afford an attorney to pursue it for them. What do people have that are in the alliances that they wouldn't have if they were getting health care from a plan outside of the alliance?

Ms. HUNTER. Well, let me just point out that included in the rights that everyone has is the right to attorney's fees, to recover if they prevail, which is a big improvement over the current system in many instances.

The difference between the individual in the corporate alliance and the individual in the regional alliance is that the individual in the regional alliance also has the option to file an action in State court, in a court of competent jurisdiction. The person in the corporate alliance can only go through the administrative procedure that I just described.

As I said, this was an attempt to track more closely the current structure for persons who are enrolled in big corporate self-insured plans.

Mr. WAXMAN. Is there any reason why we shouldn't say that no matter whether you get your health care through one alliance or another right now, you are envisioning two, there may be more, that you ought to have the same consumer protections? Any reason not to do that?

Ms. HUNTER. I think the administration is committed absolutely to maximizing consumer protections and to the greatest extent possible, to equalizing those consumer protections.

What the bill tries to do is to strike a balance between the goal of maximizing and equalizing those protections and adjusting the

process of transition for some of the entities that are going to be offering plans.

Mr. WAXMAN. We want to work with you further on that.

Ms. HUNTER. We welcome that opportunity.

Mr. WAXMAN. Another witness today will express some concern that the so-called conscience clause which allows a health professional to refuse to provide service that he or she has personal objection to could allow physicians to refuse medical care to gay men or lesbians.

I know this was not the intent of the conscience clause and that this language has a long history in the abortion debate. Could you agree that the conscience clause could be used to exclude gay men and lesbians from medical care?

Ms. HUNTER. No, Mr. Chairman, the conscience clause is worded in terms of the ability or option of a provider to decline to provide an item or service, and those are the exact words of the clause, to provide an item or service.

The clause could not be invoked selectively. That is, a provider could not decline to provide a service for one class of patients and not for others. Invoking the option would have to be done across the board.

Mr. WAXMAN. The President's plan anchors most of its non-discrimination protections to title VI of the civil rights law which prohibits discrimination on the basis of race, religion or national origin, but does not contain protections against sex discrimination.

Protections against sex discrimination are striking in their absence. I assume that this was not an attempt to allow sex discrimination. Why have you not provided specific protections against gender discrimination and would you support efforts to do so?

Ms. HUNTER. You are certainly right, that there was no intent to allow sex discrimination, and we would welcome the opportunity to work with you on this issue. I do want to point out that the prohibition against discrimination by health plans does include a prohibition against sex discrimination.

We would be happy to work with you to find the best statutory standard for anti-discrimination for linkage of the financial participation rules.

Mr. WAXMAN. Later today we will hear from a number of civil rights groups, including the NAACP and the National Women's Law Center that the protections against discrimination are not adequate, specifically, they are argue that the bill should require preclearance of alliances and health plans for items such as service boundaries to prevent discrimination on the basis of race or gender.

I would like to know why your bill does not include such a preclearance process which the Federal Government now uses in other contexts to assure nondiscrimination.

Ms. HUNTER. Well, the bill does include very strong protections against discrimination. What the drafters were attempting to do in this section was to strike a balance between the goal of the administration, which it certainly shares with you and this committee, of prohibiting discrimination, and the concerns also expressed against too heavy or too substantial an amount of Federal regulation.

The balance that we struck is reflected in the consistent and explicit prohibitions against discrimination and in the private rights

of action against discrimination that are provided in the bill. Again, we would be happy to work with this committee to consider that balance and to work with you further on that.

Mr. WAXMAN. Then I am going to get your reaction to other testimony we received last week. We had a hearing on special populations and the National Council of La Raza said that two elements of the President's bill, the denial of coverage to undocumented immigrants, plus the use of Health Security Card will in combination create, and I am quoting, "Create an enormous threat to the civil rights of all Latinos in the United States, whether they are U.S. citizens or not."

The National Council feels so strongly about the civil rights implications of the bill that they are opposing its enactment in its current form, even though its universal coverage provisions would benefit millions of Latinos.

As an alternative they recommend issuing an identical Health Security Card to everyone in the United States with information as to who is not eligible encoded on the card.

What is your response to the National Council? Will the Health Security Card become a national ID card and that—will that lead to discrimination against Hispanic citizens?

Ms. HUNTER. Again, we are very committed to prohibiting discrimination against Hispanic citizens and the prohibitions based on national origin and discrimination based on English language fluency. Both protected categories are in the bill.

The approach that the bill takes on this question is to prohibit even more specifically any misuse of the card and of the unique identifier number. The bill as drafted contains both civil and criminal sanctions against anyone seeking to use the card for any other purpose other than provision of health services.

In other words, if someone were to ask an individual to produce the card in order to qualify for any benefits or to get a job or for any other reason except to obtain health services, that would be not only a civil offense but a criminal offense and that person could be prosecuted.

Mr. WAXMAN. Well, since we make it against the law for employers to hire undocumented aliens, and since so many of those green cards are unreliable, wouldn't it make sense to look at this health care card to make sure that you are not hiring somebody improperly and violating the law?

It sounds to me like you are saying if you did that as an employer, you would be violating the law in doing that.

Ms. HUNTER. That is right, Mr. Chairman. We wanted to protect against the card being used as a way to distinguish people based on having the card, and we wanted to stop any attempt to use the card for anything other than the provision of health services. The administration felt that the best way to both allow the system to have the benefits of having a card be a functional part of the system and to protect people against unlawful discrimination was to build that kind of protection in.

Mr. WAXMAN. Mr. Cooper.

Mr. COOPER. No questions, Mr. Chairman.

Mr. WAXMAN. Let me just understand more clearly. When we go into managed competition, some people fear that we are going to

have a strong incentive for health plans to maximize their income and their competitive viability, stand in the way of needed services, and you can look at it from one perspective and say they are going to stop providing necessary services, but from another perspective, what may be considered unnecessary to someone else may be considered pretty important and necessary to the person involved and that person's family.

How are we going to protect consumers against what may turn out to be market forces that will work against them, Dr. Lee?

Mr. LEE. Well, several things. First, there is the setting requirements on the plans at the State level for performance, not just financial requirements. Second, there will be a system for evaluating that performance. Third,—

Mr. WAXMAN. By?

Mr. LEE. By public entities. The State health department, in my view, would be an appropriate agency to do that.

Mr. WAXMAN. But that is not in the bill; is that right.

Mr. LEE. It is not in the bill, but—

Mr. WAXMAN. You expect the States running these programs would decide to do that?

Mr. LEE. I would definitely expect that and there is opportunity for the States during plan approval to establish performance measures or outcome measures—quality measures—as a requirement for plan approval.

Already there are a number of States that have expressed an interest in this and are in fact developing or moving in that direction at the present time.

Mr. WAXMAN. What can we provide in this bill? Let's go through that.

Mr. LEE. Well, the third thing is—

Mr. WAXMAN. The second one is if the States decide to adopt—

Mr. LEE. Right. The second is the quality report card and the information. You have to, you know, provide the data, both on enrollment data and counter data so that there is adequate information on which you can assess the plan performance in the quality report card, and the alliances have the only gauges to provide that.

The plans will produce the report card. The alliances give that information to the consumers, and we have seen several quality report cards already produced, Kaiser Permanente in northern California has produced really an initial effort in that regard, and I think quite informative when you look at it in terms of looking at that and making a decision. They have got some performances that are very good compared to the rest of the fee for service.

There are some areas, for example, if I recall on waiting time in the doctor's office, where there is a level of satisfaction that they are not happy with.

Mr. WAXMAN. This is the Kaiser report card?

Mr. LEE. Kaiser Permanente in northern California.

Mr. WAXMAN. On themselves. Would we require in this legislation that kind of information be available in a report card?

Mr. LEE. The report card would require information on consumer satisfaction surveys.

Mr. WAXMAN. And that report would be prepared by whom, again?

Mr. LEE. The plan produces the information on which the report card is based. Then the alliance makes that information available to the consumers who are choosing plans. So that is to me a major protection.

I have been talking with people in California about this. David Lawrence, who is CEO of the Kaiser hospitals and Kaiser health plan tells me that their cost containment objectives, which they are moving towards very rapidly, have been achieved largely because of the improvements in quality, both in terms of the doctor or nurse practitioner making better decisions—improving it at that level—and improving the efficiency of the plans.

They have been looking at how their system operates. They have achieved significant savings, very substantial reductions in the last few years in their rate of increase in premiums, and I think this year they were down to the CPI increase.

Now, that is well below the Gross Domestic Product increase and Dr. Lawrence says that is, in his view, entirely due to improvements in the quality of the care they are providing in the plans.

I see this competition among the plans on the basis of quality as another way of achieving the consumer protections that we are talking about.

Mr. WAXMAN. Now, Mr. Cooper has a bill that provides for competition as well. What differences do you see in the consumer protections in your bill as opposed to his bill? Presumably the incentive for the plans to develop better quality in order to save dollars would be there. It is his idea as well as yours. Report cards. Does he have report cards? I guess he has a number of alliances.

Mr. LEE. The approaches are quite similar in many regards and I think he would speak more authoritatively on his plan than I would in terms of the consumer protection provisions.

Mr. WAXMAN. Have you read his plan?

Mr. LEE. I have read his bill.

Mr. WAXMAN. Tell me the differences.

Mr. LEE. To me the biggest difference is everybody is covered in the President's plan, number one, and they are not—

Mr. WAXMAN. I understand that, but for those who are covered in his plan may be all the people, it may be less than all the people. They are going to choose between plans, and I am just asking about one aspect of the text for consumers not to be ripped off, if I can be blunt about it. You buy a plan that is out there to try to make money. You can provide great quality of care as a way to keep people healthy.

On the other hand, if you don't give people care, that saves money too because you don't spend the money you received on a capitated basis to—you don't have to spend it.

Mr. LEE. Well, I believe in the President's plan, the public health provisions in the plan provide greater assurances than are in Congressman Cooper's bill. But in both cases, there is an alliance structure, there are competing plans, and it is my view that in both of those cases, the competition will, in fact, be increasingly on the basis of quality.

Consumers will judge the plans on the basis of quality and that is where the report card will be very, very important.

Mr. WAXMAN. Mr. Cooper, do you have anything you want to say on this since I am talking about your plan?

Mr. COOPER. Our bill, as the chairman knows, is only 300 pages long, whereas the administration bill is, I think it is 1,342 pages long, so they go into commendable detail on a number of subjects.

Our approach, as you know, originated 2 or 3 years ago when we first introduced a bill in the last Congress and the debate has evolved. We have learned a great deal from hearings, like the one today that the chairman has provided, not only for Members, but for the country, so that everyone can learn more about the incredible intricacy of these approaches.

As the chairman knows, these are perhaps the most complex bills to come before Congress in decades, perhaps 60 years. I think the information-gathering process is vital to this debate. Some of us believe more in marketplace reform than perhaps others. I think that competition, when it is a level playing field, when there is full public information on price and even more important, quality, and ideally we could have a system of genuine outcomes reporting so that it is simplistic. Simplistic insurance claims data would not be the guiding light, but we could look at whole health outcomes to see how each plan is doing serving the public, to disclose that to the public. We would go beyond that and have a consumer satisfaction rating, a poll, popularity rating, because the people will speak out. They will let you know who is friendly, who is not, who is caring, who is not, and I think those pieces of information should be before the public so that the public is well armed when they go into this selection process, this open season.

Federal employees have had an open season now for 33 years. Even the Heritage Foundation says it is one of the best Federal Government programs ever.

Mr. COOPER. We think it is high time we share system with the public so that Federal employees and Congressmen are not treated differently. We are not treated better, that everybody is treated the same. The Federal employee menu system, with all of its advantages and disclosural price, has no quality measure, has no consumer satisfaction measure, and it is impossible to compare apples with apples because they are each providing different benefits packages.

Sometimes we are seduced, as a senior member of the Ways and Means Committee was recently, into paying a whole lot more money for slightly better dental benefits because he is not a Ph.D. in actuarial science, he doesn't know whether it is worth it to pay that price difference. I think the quality revolution is one of the most exciting things that we can bring to medical finance.

As the chairman well knows, today's largely fee-for-service system has swung the pendulum way in the direction of excessive testing. Dr. Koop has said that as many as one-third of medical tests in America are at least unnecessary, if not dangerous to our health.

How do we swing the pendulum back? We do not want to go in the direction the chairman is suggesting, toward minimal testing, toward testing that does not take into account the best interests of the patient, the welfare of the patient. We want the pendulum to stop somewhere in the bottom for appropriate testing, where it is

not too much and it is not too little. Reaching that goal is going to be difficult.

Capitation, I think, will head us in that direction. That is a difficult term for a lot of my colleagues and folks back home to understand, but essentially we call it "bidding for business", "one price for all", and in that way, I think we will see a day in which we not only get lobbied by folks who want to make money drilling teeth, we get lobbied by folks who want to fluoridate water supplies so that we can prevent those cavities, we can head off the injury or illness.

I would be happy to yield to the chairman.

Mr. WAXMAN. I didn't want to interrupt you. But it sounds to me like some of the ideas that are now being discussed to make sure that we have the public health component in place and consumer protections and information, are things that you think would be worthwhile as you look at a managed competition system.

Mr. COOPER. Absolutely. I have felt this way for some time. I don't want to endanger the popularity of the witnesses here by my congratulating them on their testimony, but there is a great deal in common here that I think we should stress. The press likes to dwell on the many differences between our approaches, but our approach is more similar to the White House approach than any other bill in Congress. We are proud of that. We still want to talk about some of the differences, but we should stress the many similarities as well.

Mr. LEE. We would be glad, Mr. Chairman, to submit a more detailed analysis on these issues that you have identified with respect to the two bills.

[The information follows:]

With regard to consumer protections and information the President's Plan and the Cooper bill are very similar. Like the President's bill, H.R. 3222 provides that the regional cooperatives, HPCC's, provide eligible individuals and employers information, in comparative form, on the prices, health outcomes, and enrollee satisfaction of different health plans.

In the area of consumer protections, the Cooper bill requires that the HPCC's develop procedures for the receipt and disposition of complaints and for the appointment of an ombudsmen to examine the effectiveness of the HPCC's process and to help health plans and individuals resolve grievances with the HPCC's. The health plans, in turn, are required establish procedures for hearing and resolving grievances between the plan and enrolled individuals. The President's Plan provides the same protections, but in addition sets forth specific rights and remedies for establishing claims for coverage and reimbursement.

Mr. WAXMAN. Now, let me ask you this question because you are our witness: One of the concerns I have in a market-based system is that some people don't always get to choose. It seems to me the very strong part of the idea of a managed competition or a competitive system is if you don't like the plan, if you don't think they are doing a good job for you or your family, you leave and you go to another one. But for poor people, they won't be able to vote with their feet because they will have only a limited chance to do any kind of voting. Their subsidy won't allow them to move from the plans that they can afford, and they are at the mercy of their current gatekeeper.

What special protections do you think we ought to have for poor people? Do you think we ought to subsidize poor people to have choices so that we don't find them only stuck with one choice?

Mr. LEE. Certainly we believe very strongly in choice. It has been my impression that the subsidies would provide that, and that of course needs to be perhaps further explored with you and other members of this committee.

The other factor, and we discussed this at the last hearing, are the Public Health Service access initiatives, where you don't have choice if you don't have providers in your area—in a rural area or an inner-city area—the access initiative in the President's plan, which includes funding for the safety net providers and capacity expansion, such as expansion of the National Health Service Corps would help to assure the availability of services. This is critically important in assuring choice for individuals. If there is no—

Mr. WAXMAN. I was asking the question in terms of some family that is low income, and we want them to be part of this system as well, but if we talk about a market-based system of competition between plans, if they can't afford except one plan, they are stuck; so you think that it is important to give them a choice?

You think maybe your bill does that. But you think it is important to be able to have a choice, and if they can't exercise that choice because of their inability to pay that, we ought to provide some means so that they could have that choice?

Mr. LEE. I think the bill does that. The subsidies are fairly complicated and the provisions to protect small employers and others to permit that kind of choice, but if this requires more exploration, certainly we are prepared to do that.

Mr. WAXMAN. OK. Well, I thank you very much. Appreciate your testimony. It has been very helpful. We will certainly have a lot to work with you on.

Mr. LEE. Thank you, Mr. Chairman.

I just wanted to make sure in closing that I didn't cause any confusion in my statements about the plans and their achieving public health objectives. The public health agencies continue to have the primary responsibility and we will hold the plans accountable, but we are not going to withdraw from our public health responsibility. Our intention, as you know, in this, is to have the Centers for Disease Control and Prevention carry out these responsibilities, and we think that gives us additional assurances with respect to the performance evaluation and the quality dimensions of this effort.

We appreciate the chance to be here.

Mr. WAXMAN. Thank you very much.

Our first panel today will focus on the impact of the President's plan on public health. Dr. John Lumpkin is the director of the Illinois Department of Public Health in Springfield, MO. He is testifying today on behalf of the Association of State and Territorial Health Officials. Fernando Treviño is executive director of the American Public Health Association here in Washington. Dr. Margaret Hamburg is the commissioner of health for the City of New York. Dr. Hamburg is well known to this subcommittee, having testified on many occasions on public health issues, most recently on tuberculosis.

Dr. Molly Coye is senior vice president of Health Dimensions, a company based in San Jose, Calif. Last spring she appeared before us in her capacity as the director of the California Department of Health Services.

Thank you for joining us today. Your prepared statements will be in the record in full.

What we would like each of you to do is to limit your oral presentation to no more than 5 minutes.

Dr. Lumpkin.

STATEMENTS OF JOHN LUMPKIN, ON BEHALF OF ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS; FERNANDO M. TREVIÑO, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION; MARGARET HAMBURG, NEW YORK CITY HEALTH COMMISSIONER; AND MOLLY JOEL COYE, SENIOR VICE PRESIDENT, HEALTH DIMENSIONS

Mr. LUMPKIN. Thank you, Chairman Waxman, for the opportunity to present to you. I would like to make one small correction. The Illinois Department of Public Health is in Springfield, Ill., at least the last time I checked, although sometimes with the way the river has been flowing over the last year sometimes these things do change.

Sixteen years ago, the son of an African-American steel worker, who had only had a 9th grade education himself, began working as an emergency physician on the south side of the city of Chicago, serving the community that his father's coworkers lived in. I treated people who had nowhere else to go, who came into that emergency department.

Although I was quite elated and proud, as was my father, I was also quite surprised working there because I treated illnesses like tuberculosis and measles that I thought had been conquered, because I had been taught in medical school that we had the tools to conquer them.

Mr. Chairman, reform in managed personal care will not solve the problems that I faced as an emergency physician working in the inner-city emergency department. I looked for solutions to those problems, and those solutions led me to change my career and go into the field of public health, because I realize that a casualty-based system could not correct these problems.

In 1900, the leading cause of death in this country were pneumonia, dysentery and tuberculosis. Life expectancy was just 49 years. We spent 4.5 percent of our Gross National Product on health care. Sixty years later, life expectancy had gone up 20 years, and we were still only spending 4.5 percent of our Gross National Product on health care. This great tremendous leap in life expectancy was due to basic public health interventions—sanitation, protecting the air, protecting the water that we drink, and the food that we eat.

In the last decade, the proportion of dollars being spent on public health as a percentage of health care dollars has dropped 25 percent. In the same time, we have seen that the high-tech, casualty-focused health care system has gone, tremendously increased in cost, and now encompasses 14 percent of the Gross National Product. In that 30-year period of time, we have only seen a 3-year increase in life expectancy, and for African-American males, life expectancy has gone down.

Under health care reform, who will be responsible for contacting and counseling friends of coworkers, of patients with tuberculosis?

Under health care reform, who will follow up and assist the family of a child with lead poisoning to go into the home to do remediation?

Under health care reform, who will put the pieces together when many people from different accountable health plans become ill with the same infectious disease? Under health care reform, who will educate the public about health care crises, such as the measles epidemics we have just recently had in the city of Chicago or the outbreak of E. coli in hamburger in Seattle or Cryptosporidium in the water in Milwaukee? Every day public health workers are accomplishing those tasks with short funds, short staff, and long hours.

To make health care reform work, we need a strong focus on prevention, a strong core of public health. To make health care reform work, we need a dedicated, predictable source of funding, we cannot survive on a competitive grant.

We need to have straight funding for our health agencies to be able to plan and carry out functions. To make health care reform work, we need to have trained personnel, we need to allocate GME slots to preventive medicine as well as other medical treatment and training. To make health care reform work, we need to rebuild the eroding public health infrastructure.

Mr. Chairman, more specific proposals are included in our written testimony, as you mentioned, but let me leave you with this one thought: The average term for a State health officer is 2½ years. By the time health care reform is passed and implementation begins, most of us will have moved on to other positions, but the people in our States will remain with the same need, to have health included in health care reform.

We seek these changes to create a system that will not bankrupt States, because the only way to prevent that is to have a strong emphasis upon prevention in this health care reform.

Thank you for your indulgence.

Mr. WAXMAN. Thank you very much, Dr. Lumpkin.

[The prepared statement of Mr. Lumpkin follows:]

Statement of

John Lumpkin, M.D., M.P.H.

Representing the Association of State and Territorial Health Officials (ASTHO)

Mr. Chairman and Members of the Subcommittee:

I am John Lumpkin, M.D., M.P.H., director of the Illinois Department of Health and a member of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officer in each state and U.S. territory. I am pleased to appear before you today to present testimony on behalf of state public health agencies. The topic I have been asked to address is "traditional" public health.

We commonly think of public health services as those such as identifying and controlling disease outbreaks; immunizing children and adults; protecting the indoor and outdoor environment; assuring the safety of housing, workplaces, food and water; and monitoring the quality of health care services. These activities target the entire population to create an environment in which communities can be healthy, rather than targeting individuals. Traditional public health has, in many cases, been undermined as many state health agencies have diverted much of their attention to health care delivery for individuals who cannot otherwise receive adequate care through normal health care delivery channels.

However, as you well know, Mr. Chairman, in recent years this country has been challenged with new and re-emerging public health crises as a result of inattention to basic public health services. Last year we saw several children die because they ate hamburgers contaminated with E. coli. Numerous people were sickened in Milwaukee from *Cryptosporidium* which went undetected in the water supply for weeks. Just last week, it was reported that more health care workers are dying of tuberculosis, an increase which can be attributed to decreased surveillance in TB programs resulting from funding cuts in the 1980s.

Why are these crises occurring in spite of soaring health care expenditures and the availability of the most sophisticated technology in the world? I believe it is because we are spending much of our time and resources fixing problems rather than building a foundation for preventing them. For this reason, state health officers look forward to a reformed health care system which will allow us to re-focus on our primary responsibilities, which we now call "core public health services."

In looking at reform proposals currently before Congress, however, it is important to point out that many reform only the "care" aspect of health care - that is, they focus on the delivery of services - and do not address population-based health protection. If we truly want to reform the nation's health care system, as well as control spiralling costs, we must put the "health" back in health care reform by focusing on population-based preventive health services.

ASTHO applauds the Administration's strong commitment to public health and prevention illustrated in the President's health care proposal. The eight Core Functions of Public Health Programs listed in the Health Security Act represent essential services which must exist in every state. However, to build a strong public health foundation for health care reform, I believe we must continue to strengthen reform legislation.

Core public health functions are those activities deemed essential to protect the health of the population. These include data collection, protecting the environment and assuring public safety, investigating and controlling adverse health conditions, informing and educating the public, providing quality assurance of health services, monitoring laboratory services, providing training

and education of health professionals, and taking a leadership role in health policy development. Although they are called essential, under the President's plan states must apply for federal funding of core services through a competitive grant process. ASTHO believes that these essential services are too critical to be supported through a competitive process, in which some states will receive funding at the expense of other states' programs. Competitive funding for core services will only ensure that states which are weak in providing public health services and in competing for grants get weaker. To allow any state not to conduct activities such as disease surveillance or investigation of disease outbreaks would compromise the effectiveness of such programs nationwide. As an alternative, we propose that grants be awarded using a formula which includes a state's population and health risk indicators.

Second, the President's bill states that the Secretary of Health and Human Services may fund "one or more" of the eight core public health functions. By their very definitions, we believe that the eight functions listed are critical to the population as a whole, and should not be funded at the discretion of the Secretary.

Third, states must have a designated, predictable source of funding for core public health programs - specifically, one that is tied to total health expenditures. In many cases, if there is not consistent federal funding, state legislatures cannot authorize staff hiring or set aside resources for matching funds. In addition, given the history of the Congressional appropriations process, it is likely that public health will receive in appropriations much less than the authorization amounts. These realities, combined with the fact that there is no mention of maintaining current block grant funding, places the future of public health funding in serious

jeopardy. We must re-think and re-design our approach to public health funding in order to develop a foundation of prevention in health care reform. ASTHO also believes that additional funds for special projects and state priority areas should be channeled through state health departments to communities to assure coordination and reduce duplication.

Fourth, I would like to state clearly that states welcome accountability for public health funding, but ASTHO believes that accountability should be based on monitoring outcomes, not on managing the process of achieving outcomes. Outcome measurements should be based on progress in meeting objectives outlined in the *Healthy People 2000* document, as well as in implementing the eight core functions.

Fifth, data collection is considered a core function in the President's proposal. Public health data systems are used to identify clusters of diseases or other changes, such as a surge of teenage pregnancies, which provides warning that the public health system must intervene. Public health investigations can lead to increased efforts to immunize children, to improved outreach to specific communities, or to a public information campaign designed to increase awareness. No regional health maintenance organization or health alliance will be able to monitor statewide trends or identify urgent and emerging health problems. Therefore, it is critical that states play a central role in developing and implementing any data collection systems to assure that population-based data, as well as encounter-based data, is available in a reformed health care system.

Finally, it is critical that public health professionals are included in the development and

implementation of a reformed health care system. Public health representatives should be included on all advisory committees and councils to assure that prevention is a high priority. In addition, it is crucial that training programs for public health and preventive medicine be eligible for federal health professional support.

In summary, as you examine the President's health care reform proposal, I respectfully request that you consider the following modifications: dedicate a guaranteed source of funding for public health; require that states make available each of the eight core public health functions and assure that federal funding is available for each; replace the competitive grant process with a system which assures all states of funding necessary to carry out the core functions; hold states accountable by evaluating progress toward the *Healthy People 2000* objectives; ensure that data are available to state health agencies and that population-based data are collected; acknowledge the unique expertise of public health professionals by designating public health seats on each advisory council; and, adequately support public health training and education programs.

Mr. Chairman, I would like to emphasize that state health agencies are statutorily responsible for maintaining the health of all residents in states. We are the only entities which will continue to have statewide responsibilities after health care reform is implemented. We are very pleased to see the emphasis on population-based services and prevention in the President's bill, and we look forward to working with you and the Administration to pass and implement a reformed health care system which will benefit the population as a whole.

Thank you for this opportunity to testify.

Mr. WAXMAN. Dr. Treviño.

STATEMENT OF FERNANDO M. TREVIÑO

Mr. TREVIÑO. Mr. Chairman, my name is Fernando Treviño. I am the executive director of the American Public Health Association, the oldest and largest public health society in the world. I am honored to have this opportunity to appear before you on behalf of the association to discuss public health and national health reform.

Over the past 2 decades, our association has called for a universal, comprehensive national health care program which would remove financial, organizational and social impediments to quality health care. The need for such a program has become more urgent as health care becomes less accessible to many Americans.

Every month, 2 million Americans lose their health coverage. Over the next 2 years, 1 out of every 4 Americans will be without health coverage at some point in time. As I speak, 10 million children under the age of 18 do not have health care coverage. We cannot let this continue.

Last year at our 121st annual meeting, 12,500 public health professionals reaffirmed APHA's commitment to a single-payer approach to national health reform. We recognized that the Clinton proposal is a significant improvement over our existing system and an initial step toward achieving our goals.

We commend the administration for developing a health reform package that seeks to improve the health status of all Americans. APHA enthusiastically concurs in the administration's desire to protect and improve the health of our Nation by strengthening primary public health functions at Federal, State, and community levels.

This committee has asked us to comment upon title III, the public health initiatives of the administration's bill. One of our greatest concerns about the administration's bill is the method chosen to finance public health initiatives. The administration's proposal establishes new authorizations with the understanding that the Appropriations Committee can fund them. But given present caps on discretionary spending, the Appropriations Committees could not fund these initiatives without gutting existing public health programs.

We believe that 6 percent of total national health expenditures should be allocated to support the public health system in this country, although this figure could be cut in half if comprehensive clinical preventive services were to be included in the standard benefit package. We support a dedicated source of funding for public health. The necessary funds could be obtained by earmarking a small percentage of premium dollars, a portion of tobacco, alcohol, firearms and ammunitions excise taxes, an income tax check-off, and for general revenues.

The administration's bill establishes a new Core Public Health Functions Program. The APHA believes this proposal if adequately funded, would greatly strengthen the Nation's public health infrastructure. We would, however, propose some important modifications to the present language.

The Centers for Disease Control and Prevention should be expressly placed in charge of the program; second, the States should

be required to carry out all of the core public health functions rather than one or more as presently specified in the bill; third, the States should be required to provide baseline data and devote resources to their most serious public health problems, and not just those which have strong political support within the State; and fourth, the allocation of funds to States should not be determined solely on the basis of competitive grants, an approach which favors States which are skilled at writing grant proposals over those with less-experienced writers but perhaps more serious health problems.

Title III also establishes the National Initiatives Regarding Health Promotion and Disease Prevention, but the program is far too vague. The bill does not indicate which Federal agency will administer the program, includes no reporting requirements, and defines the entities eligible to apply for grants so vaguely that almost any group could qualify.

Absent a health agency set-aside, we are concerned that local health departments might have a difficult time competing for these dollars. Finally, there is no language clarifying how activities funded under the program will be coordinated with similar activities funded through existing categorical programs.

The Health Security Act does not discuss existing public health programs in any detail. We ask that you preserve and enhance current categorical activities. Aside from their role in clinical preventive services, these programs provide essential support for public and professional education, labor-intensive case management, technical assistance, and quality data collection and analysis.

Providing universal access to quality medical care is an important step, but it is not enough. Money is a reason, but not the only reason why many older women do not get the mammograms they need and hundreds of thousands of children are not screened for lead poisoning. Public health initiatives are needed so that we can educate the population and ensure appropriate medical and public health interventions.

When health care is reformed, our public health agencies need to be empowered to be educated about disease and injury prevention—I am going to skip that part.

As wealthy and technologically advanced as our society is, it still fails to provide an environment in which people can be healthy. Preventable diseases and injuries are pandemic in America. A national commitment to effective and relatively inexpensive public health measures would produce rapid and dramatic results in fighting the resurgence of tuberculosis, reducing injury rates and some of the other situations that have been described today already.

Attempts to achieve universal access by tinkering with the insurance system and/or requiring individual purchase of health insurance cannot alone produce a healthy society and will be particularly harmful to low-income populations. It would cannibalize rather than complement our public health efforts.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Treviño.

[The prepared statement of Mr. Treviño follows:]

Fernando M. Treviño, PhD, MPH
Executive Director
American Public Health Association

Mr. Chairman and distinguished members of the Committee, my name is Dr. Fernando Treviño. I am Executive Director of the American Public Health Association (APHA), the oldest and largest public health society in the world. I am honored to appear before you on behalf of the APHA to discuss public health and national health reform.

For over twenty years, our Association has called for a universal, comprehensive national health care program which would remove financial, organizational and social impediments to quality health care. We believe any health care reform proposal must provide for (1) universal coverage, (2) comprehensive benefits, (3) elimination of financial barriers to care, (4) equitable financing, (5) organization and administration through publicly accountable mechanisms with a major role for health agencies, (6) incentives and safeguards to assure effective and efficient organization of services and high quality care, (7) fair payment to providers using mechanisms which encourage appropriate treatment and appropriate utilization, (8) planning and evaluation with consumer and provider participation, (9) inclusion of disease prevention and health promotion programs, (10) support for health worker education and training, (11) affirmative action in the training, employment and promotion of health workers, (12) non-discrimination in service delivery, (13) consumer education, and (14) attention to non-financial barriers to service.

The need for such a program has become more urgent as health care becomes less accessible to many Americans. Every month, 2 million Americans lose their health coverage. Over the next two years, one out of

every four Americans will be without health coverage at some point. As I speak, 10 million children under the age of 18 don't have health care coverage. We cannot let this continue.

Last year at our 121st annual meeting, 12,000 public health professionals reaffirmed APHA's commitment to a single-payor approach to national health reform. We recognized that the Clinton proposal is a significant improvement over our existing system and an initial step toward achieving our goals. We commend the Administration for developing a health reform package that seeks to improve the health status of all Americans. APHA enthusiastically concurs in the Administration's desire to protect and improve the health of our nation by strengthening primary public health functions at federal, state, and community levels.

This Committee has asked us to comment upon Title III - the Public Health Initiatives of the Administration bill. In light of time constraints, I will limit my remarks to discrete portions of Title III.

One of our greatest concerns about the Administration bill is the method chosen to finance public health initiatives. The Administration proposal establishes several new authorizations with the understanding that the Appropriations Committee can fund them. But given present caps on discretionary spending, the Appropriations Committees could not fund these initiatives without gutting existing public health programs.

We believe that 6% of total national health expenditures should be

allocated to support the public health system, although this figure could be halved if comprehensive clinical preventive services are included in the standard benefit package. We support a dedicated source of funding for public health -- the necessary funds could be obtained by earmarking a small percentage of premium dollars, a portion of tobacco, alcohol, firearms and ammunitions excise taxes, an income tax check off, and/or from general revenues.

The Administration's bill establishes a new Core Public Health Functions Program. APHA believes this proposal, if adequately funded, would greatly strengthen the nation's public health infrastructure. We would, however, propose some important modifications to the present language. For example, (1) the Centers for Disease Control and Prevention should be expressly placed in charge of the program, (2) the states should be required to carry out all of the core public health functions, rather than one or more (as presently specified in the bill), (3) the states should be required to provide baseline data and devote resources to their most serious public health problems, not just those that have strong political support, and (4) the allocation of funds to states should not be determined solely on the basis of competitive grants, an approach that favors states skilled at writing grant proposals over those with less experienced writers but more serious health problems.

Title III also establishes the National Initiatives Regarding Health Promotion and Disease Prevention, but the program is far too vague. The bill does not indicate which federal agency will administer the program,

includes no reporting requirements, and defines the entities eligible to apply for grants so vaguely that almost any group could qualify. Absent a health agency set aside, we are concerned that local health departments might have a difficult time competing for these dollars. Finally, there is no language clarifying how activities funded under the program will be coordinated with similar activities funded through existing categorical programs.

The Health Security Act does not discuss existing public health programs in any detail. We ask that you preserve and enhance current categorical activities. Wholly aside from their role in clinical preventive services, these programs provide essential support for public and professional education, labor-intensive case management, technical assistance, and quality data collection, aggregation, and analysis.

If we are to achieve the Healthy People 2000 Objectives and implement health care reform, we must ensure an adequate supply of well trained public health professionals at national, state and local levels. APHA believes the federal government should support the training of public health workers so that they can respond effectively to the entire range of public health problems including AIDS, injury control, the special needs of the elderly, and environmental and occupational health hazards.

Providing universal access to quality medical care is an important step, but it is not enough. Money is a reason -- but not the only reason --why many older women do not get mammograms. Hundreds of thousands of

children will not be screened for lead poisoning if screening is covered by their plan, but nothing more is said or done. That is where public health comes in.

When health care is reformed public health agencies will (1) educate about disease and injury prevention - explaining the importance of seat belts and bicycle helmets, (2) prevent, control, and eliminate environmental health hazards - ensuring that the water supply is safe to drink, (3) analyze community health statistics to pinpoint emerging public health problems - identifying homeless populations at high risk for tuberculosis, (4) monitor disease trends and epidemics, and orchestrate swift response to emergencies - controlling Hepatitis, E. Coli and measles epidemics, (5) reach out to provide screening, preventive services and curative care to those unserved by the private sector - immunizing homeless children against childhood diseases, and (6) ensure that communities have high quality health resources - providing laboratory services and training for health care professionals.

As wealthy and technologically advanced as it is, our society still fails to provide an environment in which people can be healthy. Preventable diseases and injuries are pandemic in America. A national commitment to effective and relatively inexpensive public health measures would produce rapid and dramatic results -- in fighting the resurgence of tuberculosis, reducing injury rates, controlling sexually transmitted diseases, eliminating childhood lead poisoning, reducing breast cancer mortality . . .

We can no longer afford to sit by, bemoaning the health care system even as we do little to change it. Attempts to achieve universal access by tinkering with the insurance system and/or requiring individual purchase of health insurance can not alone produce a healthy society, and will be particularly harmful to low-income populations if they cannibalize rather than complement public health efforts .

APHA has many other concerns about the bill before you, but time does not permit us to discuss them now. We look forward to working with you to pass legislation that will improve and protect the health of all Americans.

Thank you. I would be delighted to respond to questions.

Mr. WAXMAN. Dr. Hamburg.

STATEMENT OF MARGARET A. HAMBURG

Ms. HAMBURG. Thank you for the opportunity to testify before the subcommittee concerning the role of public health in national health care reform.

From my perspective as the head of the Nation's largest municipal health department, it is essential that any Health Care Reform Package ultimately enacted include provisions for the maintenance of core public health functions, and integration of those functions into health care services and programs. Historically, as Dr. Lumpkin has pointed out, it is public health measures that have played the greatest role in reducing disease, increasing longevity and improving the quality of life and health status of our citizens.

Today important public health activities include surveillance and control of communicable and chronic disease, protection from environmental hazards, health, education and disease prevention programs and clinical services for indigent and underserved populations. Many of these activities do not occur in a doctor's office or in a clinical setting, but they are inarguably vital to the health and well-being of the people of my city and of this Nation.

As you well know, we are now engaged in a far-reaching consideration of our health care system. This has been a very positive and much needed development. President Clinton's commitment to health care reform offers a monumental and historic opportunity to improve health throughout our Nation.

Overall, President Clinton's health plan contains elements that are essential to meaningful reform, including universal coverage for all Americans, a comprehensive minimum benefits package, and a restructuring of our service delivery system to emphasize and expand capacity for preventive and primary care. In addition, the administration's recognition of the role of public health in maintaining and promoting the health of the population is to be commended. However, as health care reform moves forward, a number of particular concerns have emerged about how public health programs and policies will in fact be reflected in the reform effort.

I would like to just briefly outline a few of these key areas: First, there must be a public health representation on the National Health Board, as it has been proposed as a decision-making body for the Health Care Reform Plan.

Second, there must be an adequate and predictable funding stream to support core public health functions nationwide. This should be accomplished in some set-aside or percentage way as part of the Health Care Reform Package rather than as a separate authorization.

Third, health care plans must integrate public health measures into the delivery of clinical services. Health care reform legislation must clearly establish this responsibility. This does not mean that a health care plan must itself conduct such functions as contact tracing, partner notification, lead abatement, or directly-observed therapy of TB patients, but what is needed is linkage.

A health plan ought to be accountable for how well it integrates these vital public health services into its clinical care. Similarly, State and local public health departments, depending upon local

needs and local disease prevalence, must be able to require health plans in their jurisdictions to integrate key public health measures into clinical care.

Furthermore, certain vital public sector clinical health services may need to survive the enactment of health care reform legislation. Local health departments have developed an array of clinical services that treat individual patients but whose mission is more broadly designed to stem the spread of infectious disease or abate sources of environmental or occupational illness.

Some examples of these clinical services include tuberculosis and sexually transmitted diseases. In cases such as these where there is an overriding public health objective and a need for disease-specific expertise, it may well be that public health departments should continue to provide the essential clinical services. Furthermore, certain public health clinical interventions are not easily undertaken by any party except the health department because these services often must combine clinical treatment with mandated public health intervention.

I have mentioned contact tracing, partner notification, inspection and abatement orders for lead poisoning prevention. These involve governmental functions that cannot be easily undertaken by private parties and often must remain within a health department's service capacity. In addition to these disease-specific control activities, many health departments offer important treatment services in a confidential fashion. In some instances, such as HIV testing, STD diagnosis and treatment or family planning services, this confidentiality protection may be crucial to the willingness of individuals to seek care.

Health departments have also provided an important function as the "provider of last resort" to the indigent and the underserved. As health care reform moves forward, we must be cautious not to eliminate or underfund these services unless we can be quite confident that the described needs will be adequately addressed by the new approach.

The Clinton reform proposal envisions the possible designation of public health clinics as essential community providers and would require such relationships for the first 5 years after the enactment of reform. But what will happen after these first 5 years? The survival of vital public health clinical services may depend upon the terms and conditions offered to essential community providers in the Health Care Reform Package.

Just to quickly mention a few other key areas, a related and major concern with the Clinton health plan is coverage for undocumented persons or illegal immigrants. Currently, the Health Security Act does not contemplate covering this section of the population, yet for New York and other major urban centers, it is essential that at least basic health services be provided to these individuals, both for their individual care and for the effectiveness of our disease control efforts. The same is true for medical care we provide to prisoners, who are also excluded from universal coverage and who are often among the sickest and poorest members of our society.

More broadly, in order to effectively reach populations that are currently underserved, it will be crucial that in addition to univer-

sal coverage, health care reform achieve full funding for the National Health Service Corps and provide adequate capital support for the development and expansion for primary care facilities. Without the infrastructure and the trained personnel to draw on, we will be unable to offer appropriate care in our inner-city communities, regardless of the level of coverage offered.

Another issue of importance to the urban poor concerns the development of a risk assessment formula to compensate for the added problems and health risks seen in this population. As you know, the nature and scope of this risk-assessment mechanism is yet to be established.

Finally, I just would like to emphasize that I think the public health community has an important role to play in the development of quality assurance measures to assess the effectiveness of health care. You discussed that some earlier this morning.

The final measure of all health care reform efforts will be their impact on the overall health of the population served. The tools and know-how for measuring the population's health exist within the purview of public health. These public health tools should be applied to the overall health care reform effort as well as to monitor the impact of individual health plans and regional alliances. I have gone into more detail in my submitted testimony.

Thank you very much.

Mr. WAXMAN. Thank you.

The written testimony will all be in the record.

[The prepared statement of Ms. Hamburg follows:]

REMARKS BY
NEW YORK CITY HEALTH COMMISSIONER
MARGARET A. HAMBURG, M.D.

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

Monday, January 31, 1994

I appreciate this opportunity to testify before the Subcommittee on Health and the Environment concerning the role of public health in national health care reform.

From my perspective as the head of the nation's largest municipal health department, and from the perspective of my colleagues in public health throughout the country, it is essential that any health care reform package ultimately enacted include provisions for the maintenance of "core" public health functions and integration of those functions into health care services and programs.

Historically, it is important to note that despite a dazzling array of advances in biomedical technology and treatment strategies, it is public health measures that have played the greatest role in reducing disease, increasing longevity and improving the quality of life and health status of our citizens. Throughout the past century, the most significant gains in health have come from public health programs ranging from sanitary inspection, protection of public water supplies and waste removal, to control of communicable disease through immunization, diagnosis and treatment, contact-tracing and, when necessary, isolation.

Today, important public health activities include: surveillance and control of communicable and other disease; protection from environmental hazards; health education and disease prevention programs; patient-specific disease control interventions; and clinical services for indigent and underserved populations.

Many of these activities do not occur in a doctor's office or in a clinical setting, yet they are unarguably vital to the health and well-being of the people of my city and of this nation. Disease surveillance, for example, serves both as a sentinel alerting us to new or re-emergent threats, and a research tool enabling us to quickly devise interventions that stem the spread of disease. To relax surveillance -- particularly now, as the erosion of geographic barriers has made the introduction of disease threats from far-away places more likely -- is to let down our guard and imperil our people.

In addition, the formidable epidemiological tools of public health can be employed to gain deeper understanding of, and devise

interventions for, areas of public concern--such as violence and injury prevention, for example--that traditionally have not been considered health issues.

In more traditional areas, public health programs and services are ideally situated to reach populations at high-risk for a range of health problems. School health clinics and programs, sexually transmitted disease clinics, and HIV counseling and testing programs offer opportunities for prevention and early intervention efforts that are cost-effective and deserve support and expansion.

Through health education and promotion efforts, public health also has achieved success in changing behavioral patterns involving tobacco and alcohol use, diet and exercise. The benefits of such change are difficult to calculate precisely, but they are obviously immense, whether measured in decreased human suffering or economic losses averted.

Certain environmental issues, among them lead poisoning prevention, protection of the food and water supply, and asbestos exposure, require effective public communication and close coordination among a multitude of governmental agencies. Public health agencies are best positioned not only to inform the public, but in many cases, coordinate the governmental response to these health concerns as well.

Indeed, these public health interventions reflect public health's role as "physician to the entire population." Not only are public health activities essential for attaining our national and local health objectives, but, as the proverbial "ounce of prevention," they collectively represent an extremely cost-effective element of national and local health strategies.

The nation is now engaged in a far-reaching consideration of our health care system. This has been a very positive, much needed development. President Clinton's commitment to health care reform offers a monumental and historic opportunity to improve health and well-being throughout our nation. Overall, President Clinton's Health Plan contains elements that are essential to meaningful reform, including universal coverage and health security for all Americans, a comprehensive minimum benefits package, and a restructuring of our service delivery system to emphasize and expand capacity for preventive and primary care. In addition, the Administration's recognition of the role of public health in maintaining and promoting the health of the population is to be commended. However, as health care reform moves forward, a number of particular concerns have emerged about how public health programs and policies will, in fact, be reflected in the reform effort.

Let me briefly outline for you a number of the concerns shared by me and my colleagues in public health, and how we believe they can be significantly addressed by action in a number of key areas:

1. The National Health Board that has been proposed as a decision-making body for the health care reform plan must be constituted so that it embraces public health issues on its agenda. This could be accomplished several ways, either separately or in combination. The Board could be direct, by statute, to consider public health consequences and preventive efforts in all actions it takes. A certain minimum number of Board members could be required to be public health experts, or some other way of assuring that public health expertise be reflected in Board membership can be devised. Alternatively, a separate public health panel could be established with the power to advise and consent on Board actions having a significant public health component or involvement.

2. There must be a stable and predictable funding stream to support core public health functions nationwide. This should be accomplished in some set-aside or percentage way as part of the health care reform package, rather than as a separate authorization. Toward this end, drawing from the health insurance premiums that are envisioned as the primary financing vehicle for health care reform, a dedicated percentage set-aside for public health will assure continued, reliable funding. (Public health experts have estimated the desirable level of funding for public health functions at six percent of total health expenditures). It is certainly fair and appropriate that the flow of revenues to public health from health insurance premiums should be linked to continuation of state and local funding for public health, but the funding apparatus for public health must reflect a strong commitment from the federal government and the reality that public health is an essential component of the overall health care strategy for our citizens.

Correspondingly, assured funding for public health functions should also require a quality assurance component to gauge the effectiveness of the interventions. We need better quality assurance measures for both population-wide and patient-specific public health activities. Admittedly, this is a difficult task. Public health is most successful when something does not occur--namely disease, disability, or death--and it can be difficult to accurately assess the reasons for the absence of something. Nevertheless, we must move ahead in developing outcome measurements to improve efficiency and so we can compare the cost-effectiveness of public health programs with patient-specific health care delivery.

3. Health care plans must integrate public health measures into the delivery of clinical services. Health care reform legislation must clearly establish this responsibility. This does not mean that a health care plan must, itself, conduct such functions as contact tracing, partner notification, lead abatement and directly-observed therapy of TB patients. What is needed is linkage; a health plan ought to be accountable for how well it integrates these vital public health services into its clinical care. Similarly, state and local public health departments,

depending upon local needs and local disease prevalence, must be able to require health plans in their jurisdictions to integrate public health measures into clinical care.

4. Certain vital public health clinical services may need to survive the enactment of health care reform legislation. In New York City and throughout the nation, public health departments have developed an array of clinical services that treat individual patients, but whose mission is more broadly designed to stem the spread of infectious disease or abate sources of environmental or occupational illness. Some examples of these clinical services are TB (diagnosis and treatment, contact tracing and notification, directly-observed therapy, and drug-susceptibility testing), sexually transmitted disease (diagnosis and treatment as well as linking patients to partner notification services), school health programs (ensuring immunizations, screening children for disease, and where appropriate, linking children and families to follow-up services), and clinical laboratory services (with individual instances of elevated lead levels, for example, triggering environmental inspections and abatement). In cases such as these where there is an over-riding public health objective and a need for disease-specific expertise, it may well be that public health departments should continue to provide the essential clinical services.

Furthermore, certain public health clinical interventions are not easily undertaken by any party except a health department, because these services often must combine clinical treatment with mandated public health interventions. These include contact tracing for STDs, partner notification for HIV, inspection and abatement orders for confirmed instances of lead poisoning and mandatory directly-observed therapy for TB. These involve uniquely governmental functions that cannot be undertaken by private parties, and must remain within a health department's service capacity.

In addition to these disease-specific control activities, many health departments offer important treatment services in an anonymous or pseudonymous fashion. In some instances, such as HIV testing, STD diagnosis and treatment, or family planning services, this confidentiality protection may be crucial to the willingness of individuals to seek care.

Health departments have also provided an important function as the provider of last resort to the indigent and underserved.

As health care reform moves forward, we must be cautious not to eliminate (or underfund) these services, unless we can be quite confident that the described needs will be adequately addressed by the new approach. The Clinton reform proposal envisions the possible designation of public health clinics as "essential community providers" and would require such relationships for the first five years after the enactment of reform. But what will happen after the first five years? The survival of vital public

health clinical services may depend upon the terms and conditions offered to "essential community providers" in the health reform package.

There is a strong rationale for perpetuating essential public health clinical services and paying for them through health insurance premiums. One reason for this is the achievement of economies of scale. Another justification for continued funding of these services is because they are not easily duplicated elsewhere. For example, the tuberculosis expertise that has been developed in our Department's TB control program cannot be found in most of the City's clinical settings despite the concentration and sophistication of medical institutions in New York.

A further justification for continued, guaranteed funding of public health programs is the distinct possibility, if not virtual likelihood, that unscrupulous health plans will be tempted to "dump" their own patients onto the fragile public health clinic delivery system. Clearly, the best way to protect these critical public health clinical services is to fund them from premiums and by requiring health plans to reimburse for the services their members receive at public clinics.

Yet another reason for the ongoing support of essential public health clinical services is to serve undocumented persons, who will apparently not otherwise be covered by health plans. I want to emphasize the importance of this point. Currently the Health Security Plan does not contemplate covering this section of the population. Yet for New York, as for all urban centers of the country, it is essential that at least basic health services be provided. Sadly, immigrants often have a wide array of health problems; too often, neglect and inadequate access to health care only makes these problems worse, and their treatment, ultimately, more expensive. It is penny-wise and pound-foolish to exclude these individuals from the meaningful primary and preventive care coverage offered by health care reform. What is more, given the endemic state of many infectious diseases in other parts of the world, it is critical that we are able to effectively reach these individuals and offer them care. Without this, our disease control efforts will be seriously hampered.

Therefore, in order to protect the health of both individuals and populations, and to reduce preventable expenditures, health care reform should be expanded to include undocumented persons. However, should this not happen, there must be ongoing support for the public health system at whose doorstep these patients will continue to present.

Another group that needs to be included in coverage plans, either directly or through some reimbursement system for local governments, is our prison population. Again, this is a group that has been ignored by the health care reform plans currently being circulated and discussed. But medical care for prisoners is a critical aspect of any health care and/or disease control program.

Studies in New York and elsewhere demonstrate that this is a very ill population; prisoners suffer disproportionately high rates of HIV illness, STDs, TB, and other serious, often preventable, conditions. Not only is it essential that these individuals receive appropriate care and treatment, but their diseases must be diagnosed and treated to limit their spread among fellow prisoners, or to members of the civilian population among whom prisoners live when they are released.

5. The public health community has an important role to play in the development of quality assurance measures to assess the effectiveness of health care. The final measure of all health care reform efforts will be their impact on the overall health of the populations served. The analytic tools and know-how for measuring the population's health, in turn, are found squarely within the purview of public health. In fact, existing public health programs and expertise, particularly disease surveillance and the collection and analysis of health statistics, could readily be utilized to establish vital quality assurance mechanisms for health care reform. These public health tools could be applied not only to the overall reform effort, but to monitor the impact of individual health plans and regional health alliances.

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In summary, there is a pressing need for health care reform in this country. However, if these efforts are to be successful, it is essential to consider all the major factors that influence the health of the public; it will require explicit, systematic and sustained attention to the core functions of public health. Despite the manifest, fundamental significance of public health activities -- and despite their proven track record of accomplishment -- these functions have historically been marginal in American debates on health care. This time we cannot afford to leave them out.

Implementation of the suggestions I have outlined would assure preservation of public health activities that are immeasurably important to this nation's well-being, and will further the health objectives we have delineated for ourselves as a nation. Failure to integrate public health concerns into the strategy, objectives, and workings of health care reform will threaten these critical functions, with possibly disastrous consequences nationwide.

Again, thank you for the opportunity to address the important issue of preserving these essential public health services as the nation goes forward with health care reform.

Mr. WAXMAN. Dr. Coye.

Do you want to pass the microphone over?

STATEMENT OF MOLLY JOEL COYE

Ms. COYE. Good morning, Chairman Waxman. Thank you for the invitation to appear before you again.

My name is Molly Joel Coye. I am a physician licensed in California and board certified in preventive medicine. I have been the director of health for two State Health Departments, chair of the executive board of the American Public Health Association and president of the Association of State and Territorial Health Executives.

As you also know, I am that relatively rare entity, a "dyed in the wool" public health professional who is enthusiastic about the potential for managed care and organized delivery systems. So I am very interested in addressing this topic from my new position, working with Health Dimensions, which is a community-based nonprofit integrated health system in San Jose, Calif.

Our system includes four community nonprofit hospitals, a medical group and an IPA, a trauma center, regionalized tertiary services, and in total serves approximately one-fifth of the people living in Santa Clara County. Our system, however, also includes 10 school-based clinics, more than any other local health system in the country, as well as the largest nonprofit home care agency in our county, of which I am now acting CEO, and mental health, HIV prevention as well as treatment, and many other services that are directly related to the public health of our community.

We are, in fact, a part of the broader public health network within our community, and as we move towards capitation, we are transforming ourselves into an organization that takes a population-based approach to health care. From this new perspective, and with perhaps a unique combination of experience in the public and private sectors, I want to argue the urgency of several public health concerns in the broader context of national health reform.

Most important of all, we need a strong, competent public health system as our partner in this reform effort. The best of managed care, the best of organized delivery systems still requires a strong public health presence at the local, State and Federal level to complement, lead and provide services that we will never provide.

The President's plan offers us a great promise, the possibility with universal access that our public health agencies will finally have the monkey off their back, will finally be able to turn their attention to real prevention and public health. But there are some tremendous risks in this transition period.

The first risk, and one which I believe, Chairman Waxman, you have identified very well, is that it will be a period of great tumult and change. Some systems may be rapidly dismantled, while the new ones intended to replace them are not yet serviceable.

This could result in the public health equivalent of deinstitutionalization in mental health, and as you know, in that case, the replacement services never materialized. Because of this, I support the President's proposal that special status be accorded to public and community nonprofit systems and providers during the transition period, and that funding reach them early during this period

to begin the development of the public health and medical care systems which we will need in the future.

The second great risk of this transition period is that the public health needs of the country will receive lip service only, authorization without appropriation.

I know you, Mr. Chairman, and members of the subcommittee, are well aware of the principal causes of disease, death and disability in our country, but not everyone understands that medical care and the health of the public are only tangentially related. Much of the public believes that health reform will make us healthier. This is patently untrue.

Giving everyone in the country a health insurance card will not alone significantly improve the health of our people. Only a combination of reforming the medical care system and reform in our public health system can do that. So I urge you to support full funds and apply full pressure for reform of the public health system as well as the medical care system. And I will tell you why I feel so strongly about this.

Frankly, the public health system in America is just as badly in need of basic reform as the nonsystem of medical care. The public health system needs adequate data systems, accountability, and a concentrated effort to make publicly administered programs more effective.

Having directed the efforts of two large State health departments and worked closely with local health departments in three States, I know how large an undertaking it will be to create a modern, streamlined, efficient and responsive public health network, but we desperately need reform in the public health system and a strong public health system. Public health agencies today are organized by scientific discipline, by media of exposure, by disease, by financing source, by legislative authorization.

In a historical accretion that owes much to Rube Goldberg and very little to strategic planning, authority over programs is fragmented among agencies within each level of government and diffused across local, State and Federal levels. A typical State agency operates literally dozens of programs, each with separate contracts, billing eligibility criteria, applications, data collection and reporting requirements, audits, and so on, resulting in a spaghetti web of overlapping and contradictory programs targeting the same populations.

Each categorical program accumulates its own collection of entitled interests, including the program staff itself, to oppose any consolidation or integration of that program. This fragmentation and disarray is not unlike the situation in medical care today. Both are nonsystems. Both require reform, accomplished with care, but also with determination. In both cases, reform should lead to integrated, flexible systems that can direct resources more effectively to prevent disease and death.

And in conclusion, Mr. Chairman, there is more in the written testimony that I will submit, I believe very strongly that managed care and organized delivery systems can fulfill the promise that the President believes in, but only with strong public health partners, and the failure to provide enough funds and I believe somewhat stronger requirements in terms of accountability, endangers this parallel process of reform.

Mr. WAXMAN. Thank you very much, Dr. Coye.

[The prepared statement of Ms. Coye follows:]

STATEMENT OF MOLLY JOEL COYE

Good morning, Chairman Waxman, and thank you for the invitation to appear before you today. My name is Molly Joel Coye. I have been asked to testify today on public health and the President's proposal for national health reform. Let me first give you some bona fides. I am a physician, licensed to practice in the State of California and Board Certified in Preventive Medicine. I have served as the Commissioner of Health for the State of New Jersey, Director of the State Department of Health Services for the State of California, Chair of the Executive Board of the American Public Health Association, and President of the Association of State and Territorial Health Executives. As you know, I am also that relatively rare entity, a dyed-in-the-wool public health professional who is enthusiastic about the potential of managed care and organized delivery systems.

I left the position of Director of the Department of Health Services for California in September of last year, and since then have been Senior Vice President for Health System Development for Health Dimensions, a community-based non-profit integrated health system in San Jose, California. Our system includes four community non-profit hospitals, a medical group and an IPA, a

trauma center, regionalized tertiary services, and in total serves approximately one-fifth of the people living in Santa Clara County.

Our system, however, also includes 10 school-based clinics -- more than any other local health system in the country -- as well as the largest non-profit home care agency in our county, of which I am now acting CEO, and mental health, HIV prevention and treatment and many other services that are directly related to the public health of our community. We are a part of the broader network of public health within our community, and as we move to capitation, we are transforming ourselves into an organization that takes a population-based approach to health care. From this new perspective, and with a unique combination of experience in the public and private sectors, I want to argue the urgency of several public health concerns in the broader context of national health reform.

Most important of all, we need a strong, competent public health system as our partner in making communities healthy. The President's proposal to achieve universal access to medical care in this county promises us this potential, but it does not go far enough if it remains unfunded. For many years, those of us working in public health have been forced to devote the lion's share of our efforts and our budgets to providing access for the underinsured in our communities. The true mission of public health -- to promote the health of our communities -- has been sacrificed to the more pressing human and political necessities of providing medical care for those who cannot access it in the private sector. If national health reform does in fact provide this access, public health agencies will at last be able to turn their attention to the broader tasks of

Dr. Molly Coye / 4

public health, and be effective partners with the transformed system of medical care delivery.

It appears that the transition to universal access will be prolonged as the content and cost of health reform continues to be negotiated. The transition to a system of universal access to medical care, and especially a prolonged transition, poses several very real risks for the vulnerable populations we have traditionally served. First of all, the transition itself will be a period of tumultuous change and great uncertainty. Some systems may be rapidly dismantled while the new ones intended to replace them are not yet serviceable. This could result in the public health equivalent of deinstitutionalization in mental health -- and, as you know, in that case the replacement services never materialized. Because of this, I support the President's proposal that special status be accorded to public and community non-profit systems and providers during the transition period, and that funding reach them early during this period to begin the development of the public health and medical care systems which we will need in the future.

The second great risk of the transition period is that the public health needs of the country will receive lip service only -- authorization, without appropriation. I know you, Mr. Chairman, and the Members of the Subcommittee are well aware of the principal causes of disease, death and disability in the United States. But not everyone understands that medical care and the health of the public are only tangentially related. Much of the public believes that health reform will make us healthier.

This is patently untrue. Giving everyone in the country a health insurance card will not alone significantly improve the health of our people. Only a combination of reform in the medical care system and in public health can do that. So I urge you to support full appropriation of the funds proposed for the reform and improvement of the public health system. And I will tell you why I feel so strongly about this.

Frankly, the public health system in America is just as badly in need of basic reform as the non-system of medical care. The public health system needs adequate data systems, accountability, and a concentrated effort to make publicly-administered programs more effective. Having directed the efforts of two large state health departments, and worked closely with local health departments in three states, I know how large an undertaking it will be to create a modern, streamlined, efficient and responsive public health network. We need these reforms to create a public health system capable of protecting and advancing the interests of the public.

We dare not assume that Alliances -- or individual provider systems -- will be tough enough as monitors of two concerns that have traditionally been the responsibility of public health agencies: access to care for vulnerable populations, and population-based prevention. But we should be equally careful about assumptions that public health agencies do an adequate job at either of these tasks. In an era of increasing accountability, public health agencies will find that they too have to transform themselves, from their current hodge-podge of categorical programs into true systems capable of comprehensive and

effective leadership.

Public health agencies today are organized by scientific discipline, by media of exposure, by disease, by financing source, by legislative authorization -- in an historical accretion that owes much to Rube Goldberg and little to strategic planning. Authority over programs is fragmented among agencies within each level of government, and diffused across local, state and federal levels. A typical state agency operates literally dozens of programs, each with separate contracts, billing, eligibility criteria, applications, data collection and reporting requirements, audits, and so on, resulting in a 'spaghetti web' of overlapping and contradictory programs targeting the same populations. Each categorical program accumulates its own collection of entitled interests, including the program staff itself, to oppose any consolidation or integration of that program.

This fragmentation and disarray is not unlike the situation in medical care today. Both are 'non-systems'. Both require reform, accomplished with care but also with determination. In both cases, reform should lead to integrated, flexible systems that can direct resources more effectively to prevent disease and death. In the reform of public health agencies this would mean the establishment of broad program budgeting for all core public health programs, with a common data base, defined outcomes and performance benchmarks. Categorical programs should be consolidated into comprehensive systems, as the means of holding them accountable are developed and put in place.

And public agencies must be allowed to target resources in order to concentrate on priority risks. In every community, a short list of attributable risks, mostly related to behavior (tobacco, alcohol, violence, diet and exercise), are

responsible for the vast majority of premature deaths and years of potential life lost. Because of the detailed extent of executive and especially legislative political control over funding decisions at all levels of government, however, it is often difficult for agency administrators to make sensible, outcome-driven decisions about resource allocation and program priorities. There is far too little use of the mother science of public health -- epidemiology -- in determining the allocation of resources and priorities in public policy.

These are some of the tasks I find for the reform of our public health system. The President is right -- we should reform the public health system, and incorporate it directly into the broader reform of our entire health system. But reform efforts of any substance require investment. It takes working capital to build modern information systems, to train and re-organize workers, to refurbish laboratory and other technical systems, and to establish new methods of accomplishing old tasks. If we fail to invest now in the reform of public health, we will miss a critical window of opportunity and condemn ourselves to another generation of monies misspent on secondary and tertiary treatment of preventable conditions.

The potential if we do undertake to fund and reform public health is truly exciting. Hospitals, and especially the physician-hospital integrated systems and community provider networks, are beginning to think in population-based terms because of the incentives of capitation and the satisfaction of beginning to form integrated systems. We have a tremendous opportunity to broaden the participation in public health efforts within each community, to capitalize on the profound transformation now unfolding within traditional provider systems, and to guide these emerging local health systems into a collaborative network of public health agencies, community-based physician and hospital organizations, and other community service organizations.

If we believe that health reform should actually *improve* the health of the public -- as well as provide access to medical care -- we will have to invest in strategies which can accomplish this goal, and incorporate the budget for public health into the basic budget for health reform.

Mr. WAXMAN. Just following up on your point and asking this question to get this clearly for the record; at the Federal level, as you know, we often find it hard to get money for programs to prevent problems. Most of the time the money doesn't come until the problem is a crisis.

As you have heard this morning, the same is true in the Clinton health bill. There is money for treating illness, but not for the public health programs to prevent it. Some have argued that the prevention programs are State and local responsibilities. Have you been more successful in getting preventive money?

Let me address that to those of you who have been working at the local—all of you have been working at the local level.

Dr. Lumpkin.

Mr. LUMPKIN. Well, certainly part of the problem with the public health infrastructure is that for so many years we have focused as a society on casualty treatment, and just as you have said, funding has been short on the national level, and funding is short on the State level and on the local level. When we have to compete with the Medicaid program for preventive funds—and there is perhaps the most classic example in Illinois, and not saying that this is a bad program, but for the long-term care program in Illinois, we spend \$1.2 billion, and it services 60,000 individuals.

We on the State level spend \$100 million, less than 10 percent of that on public health programs which impact all 11.5 million people in the State of Illinois. There is a disparity there. Unfortunately, we as a society have mortgaged our future in public health by not paying for it.

Mr. WAXMAN. Dr. Treviño, do you want to comment about that?

Mr. TREVIÑO. I will pass.

Mr. WAXMAN. Dr. Hamburg.

Ms. HAMBURG. I guess one additional comment or observation I would just make is that, unfortunately, within our New York City Department of Health, and I suspect other health departments across the country, in times of constricting budgets there has been a sad tendency to squeeze the prevention programs more than the clinical programs. And I think in many ways that reflects the fact that the products of prevention are much harder to measure, that it is not so obvious to the policymakers or to the public when a prevention effort is in place and when it is successful. In fact, our very successes are the absence of disease, so there is much greater pressure and much more public outcry when clinical services are reduced.

One of the aspects of the Clinton Health Care Reform Plan which I welcome in that regard, is that if we can shift some of our more or less straightforward and traditional ambulatory primary care services out of the health department and see that those services are in fact provided through the inclusion of primary and preventive health care services in the basic benefits package, then we will be able to focus much more to really strengthen and expand our primary mission in public health, which is, of course, prevention.

Mr. WAXMAN. Dr. Coyle.

Ms. COYE. I would like to take a somewhat different point of view. In two very tough budget cycles in California, as you know, with one programmatic exception, we were able to protect entirely

our prevention budget and cut Medicaid. So while we are not particularly proud of cutting Medicaid, I think it is possible to defend a prevention budget.

But I think that the more basic phenomenon that Dr. Hamburg and others are addressing is that basically the medical care services public health departments provide are to poor people, and the prevention programs are for the whole population, and so when the budget tightens up, there is a real willingness to cut things which people don't care about; for example, health care for the poor or things that they don't understand well, like prevention, and it is Hobson's choice to balance these two things off against each other. That is why it is so important to have an established funding stream for the public health side and to fold in the care of the poor into systems that are paying for the care of everybody.

Mr. WAXMAN. States and cities have a wide variety of public health needs. Some large urban areas have severe infectious disease problems, some don't; some have decaying infrastructures, others don't. How should we allocate funding across State lines?

Should we just give money out on a population basis and ignore the severity of need or should we give out the money on the basis of need-using criteria, like infectious disease and infant mortality?

Mr. LUMPKIN. I see where, Mr. Chairman, you don't ask easy questions. I think that—

Mr. WAXMAN. I have staff that wants to get to the bottom of this.

Mr. LUMPKIN. I think that certainly there is no either/or choice in this. I think that the funding formula should take into account not only population but also need. There are States—Illinois is usually about 4.9 percent of the population of the country, but we also have many significant social problems. I think those have to be taken into account in some formula that would include not only population but also incidences of certain target diseases, HIV would be one, poverty would be another.

Mr. WAXMAN. Dr. Coye, I want to skip to you on that question because you made the very articulate case for a reliable funding source. But if we are going to have a reliable funding source that involves Federal dollars, how do you think it ought to be allocated?

Ms. COYE. OK, well, here is my shot. I would say, first of all, that you do need a formula population-based allocation. There is a bare minimum that you need for providing services everywhere, and hopefully better than bare minimum, if we can get a decent funding stream.

I think the tougher question is what kind of accountability would we attach to the attempts to solve specific problems. If you have a floor of prevention, outreach and education work going in HIV, and a floor of access to treatment services, and you have some communities with greater HIV problems than others, it begs the question to simply say: Should we give more money to that community? The real question should be: How are we going to hold accountable those who are trying to change the pattern in the community?

I would be willing to throw great resources disproportionately into areas where the problems are worse, if you had some confidence that there was accountability for their ability to impact those patterns, and that is the test. Now, obviously, people will say fairly, these are very complicated social issues, and it is very dif-

ficult to bring about change, but it is possible. And in the absence of being held accountable, it is very, very difficult for public health leaders, for example, within their own communities, to exert the kind of influence to change collateral systems that are necessary, so I would certainly put more money disproportionately into the areas that have problems.

I am not sure I would do it on a competitive grant basis, unless you could tie those competitive grants to real performance.

Mr. WAXMAN. Yes, Dr. Treviño.

Mr. TREVIÑO. Thank you, Mr. Chairman.

I think whatever system is used does have to take into account the differences that exist across our country in terms of health needs. I moved to this area 4 months ago from a State that shares a thousand mile border with Mexico. I can tell you the public health problems we experienced there are vastly different from the ones that we experience where I now reside. For example, our public health departments down there had to run leprosy clinics. I haven't checked, but I suspect Montgomery County in Maryland does not have a big problem with leprosy, and so forth, so we do have to take into account the regional differences that exist, not just the population size.

Mr. WAXMAN. Dr. Hamburg.

Ms. HAMBURG. Well, I think that my colleagues have made a number of important points. I think that some constellation of population-based measures and need, and need in terms of both medical need and social need needs to be applied to make sure that appropriate and equitable funding is made available.

I think it is very important what Dr. Coye was saying about accountability and ability to really put into place programs utilizing funds received. But that to me is the thorniest of the issues in terms of how you can measure that and how you can implement it so that it is not punitive, preventing localities that are terribly underserved and with inadequate infrastructures from being able to access resources that are so vitally needed, to put in place the bare minimum of service capacity. But I think that is the heart of the matter in terms of really getting us to the point where, as Congressman Cooper said, there is an equal playing field.

Mr. WAXMAN. Dr. Coye.

Ms. COYE. Could I add another comment, and I would be glad to submit a copy of a paper which I recently completed in which I suggested that the idea that, and this is somewhat controversial, that some of the traditional functions of public health departments ought to be put out to bid to nonprofit voluntary agencies. The reason—not in the old traditional, “let’s contract out public services in order to break the unions”, I mean, hopefully, that is not the purpose of this. The purpose of it is to uncover more effective ways of bringing about change in the conditions in our communities.

I believe personally that if we had been more able to turn over our immunization funds to the community health centers and other groups on a bonus or a bounty hunter system in the community, we might have done much better with immunization, but we are tied by the nature of the categorical programs to certain personnel structures and certain means of expenditure or patterns of expendi-

ture. So I think it would be well worth piloting some experimentation in that area with the voluntary agencies.

Mr. WAXMAN. Thank you very much. An interesting point.

Well, I thank the four of you very much for your testimony. I know you have given us very important, valuable information.

Thank you.

Our next panel will address the provisions in the President's plan to protect consumers from underservicing by health plans that are at financial risk for the comprehensive benefit covered by the bill.

Linda Golodner is president of the National Consumers League and is testifying on behalf of the Coalition for Consumer Protection and Quality. Rand E. Rosenblatt is a professor of law at Rutgers University Law Center in Camden, N.J. and is co-chair of the Society of American Law Teachers Access to Justice in Health Care Committee. He is accompanied by his co-chair, Sylvia Law, professor of law at NYU Law School.

Is Linda Golodner here?

Mr. LINDBERG. She isn't here right now.

I am going to fill in for her, if that is all right, Mr. Chairman?

Mr. WAXMAN. OK, fine.

Could you identify yourself for the record?

Mr. LINDBERG. Yes, thank you.

My name is Brian Lindberg, I am the executive director of the Coalition for Consumer Protection and Quality in Health Care Reform.

Mr. WAXMAN. Thanks.

Do you expect her back soon, or are you going to fill in?

Mr. LINDBERG. I think I will have to take her place.

Mr. WAXMAN. OK. Why don't we start with Mr. Rosenblatt.

Let me indicate to both of you, all three of you, that the prepared statements will be in the record in full. What we would like to ask you to do is limit the oral presentation to no more than 5 minutes.

There is a button on the base of the mike. Be sure to push it forward and pull it close.

STATEMENTS OF RAND E. ROSENBLATT, CO-CHAIR, ACCESS TO JUSTICE IN HEALTH CARE REFORM, ACCOMPANIED BY SYLVIA A. LAW, CO-CHAIR; AND BRIAN W. LINDBERG, EXECUTIVE DIRECTOR, COALITION FOR CONSUMER PROTECTION AND QUALITY IN HEALTH CARE REFORM

Mr. ROSENBLATT. Thank you, Mr. Chairman.

Good morning. My name is Rand Rosenblatt, and with Sylvia Law, we are the co-chairs of the Committee for Access to Justice in Health Care Reform, the Society of American Law Teachers. We appreciate this opportunity to testify before you on these very important questions of consumer protection.

With over 800 members at 140 law schools, the society is the largest individual membership organization of law teachers, and we have been concerned with access to justice issues for a long time. As you know, there is—we believe that there are many positive aspects of the Clinton health reform bill. We also believe there are a number of important improvements that need to be made, and as you know, there is a lot of public anxiety about this bill,

and we think these improvements would go a long way to helping alleviate that anxiety.

We see there are three major components to an adequate consumer protection system in this bill: The first has to do with individual claims through an administrative process; the second has to do with private rights of action in the State and Federal courts; and the third has to do with organized consumer advocacy systems. There are elements of this in the bill now, and we think they can be considerably strengthened.

Turning first to the individual claims in the administrative process, as you yourself mentioned in relation to the administration witnesses, there is a major question of how people are going to be able to afford assistance to move through this process. The bill does have attorneys fees provisions, and we support those provisions.

We think there is an important additional step that has to be made, and that is considerable strengthening of a system of nonattorney, lay advocates, who would help patients in the earlier stages of this process. We think that could be best done through the ombudsman office in the bill, which is with the regional alliances.

The purpose of that ombudsman office is to help consumers in their problems with the plans and the alliances. That is what the bill says. We think there are major steps that could be taken to strengthen those.

Obviously, it needs adequate funding. Right now a dollar check-off provision is very unlikely to generate adequate funds for this. We would suggest something more like 1 percent of premium to cover the millions of claims and potential disputes that could arise in this system.

Second, we think that the ombudsperson office has to have some access to medical expertise. As you know, in a managed care system, it is not easy for the patient to find expert advocates on their behalf if they have a dispute with the plan about a medical necessity determination or something of that sort.

One possibility would be to pay for second opinions. Another, perhaps more efficient, would be to fund the ombudsperson office to be able to supply some of that expertise. We also believe there should be at the national level a center for advocacy that would help both the ombudspeople and the private attorneys negotiate this quite complex system.

Second, we believe that independence of judgment for all levels of the claims process is very important. It was revealing that the administration witnesses referred to the hearing officers, what is called in the bill hearing officers, as ALJ's or State ALJ's. We believe they should have those protections. Those protections are not now in the act.

We believe the Federal Health Plan Review Board and the National Health Board should all have protections for independence, they should have terms of office, they should have protections comparable to or better than the current Federal ALJ's.

Third, again relating to your concerns about managed care and consumer rights, it is very important to define what a claim is in this system. As currently worded in the act, a claim would work well for a traditional insurance plan, a claim for payment. It is not

clear how well it would work in a prepaid, at-risk managed care system where patients don't typically file claims for services after being delivered.

There are a number of models for how to deal with this. One of them is in the current Medicare regulations for HMO's. We think that the focus should be on—patients' belief of what they are entitled to should be a significant factor in determining what a claim is.

Fourth, need for access to courts, very important as a back stop to the administrative system to make sure it is working adequately. The \$10,000 amount in controversy is very high. It actually reduces the rights currently available to Medicare and Medicaid beneficiaries.

We believe the amount in controversy shouldn't be higher than \$1,000, and there should be access to district courts instead of courts of appeals and there should be allowed aggregated claims for smaller amounts that raise important issues. Congress recognized this in 1980 when it abolished the \$10,000 amount-in-controversy requirement for Federal question jurisdiction. There is no real relationship between the amount of money and the importance of the issue.

Fifth, an issue that you alluded to in the earlier panel, there has to be adequate damages to protect consumers in the managed care system. One of the administration witnesses testified that members of corporate alliances wouldn't be able to go into court, and that relates to the ERISA preemption issue. I agree with you completely, ERISA shouldn't be relevant to this anymore. We are moving to a different system, and the ERISA preemption of State law should be repealed. Also, by the way, I agree the corporate alliances should also have ombudspeople and they should have a full range of rights.

In addition, there is a very important issue—how am I doing on time?

Mr. WAXMAN. Your time has expired. I know you put a lot of effort into your written statement, and we will have a chance to go through that whole written statement. We appreciate it.

Do you want to make any concluding comment?

Mr. ROSENBLATT. Let me just say that in the rights-of-action there are two major issues: One has to do with enforceability in the Federal courts. We have proposed a provision in the testimony that would make clear to the Federal courts that these provisions of the act are indeed rights that are enforceable. This is no longer clear in Federal doctrine and it needs to be made clear.

The second big issue is there needs to be rights-of-action against Federal administrative officials as well as State and local officials.

Mr. WAXMAN. I thank you very much.

I think the work you have done is going to be very helpful for us as we move toward markup in the subcommittee.

[Testimony resumes on p. 460.]

[The prepared statement of Mr. Rosenblatt follows:]

STATEMENT OF RAND E. ROSENBLATT

Good afternoon, Mr. Chairman and members of the Subcommittee. My name is Rand Rosenblatt. I am a professor of law at Rutgers University Law School at Camden, New Jersey, specializing in health law, and co-chair of the Society of American Law Teachers Committee on Access to Justice in Health Care Reform. We want to thank you for holding this hearing on consumer protection issues related to President Clinton's health care reform proposal. We appreciate the efforts of the Administration and Congress in tackling the extremely challenging and important issues of health care reform, and we appreciate the opportunity to testify.

With almost 800 members at over 140 law schools,, the Society of American Law Teachers (SALT) is the largest individual membership organization of people who teach in American law schools. Since its inception in 1974, SALT has addressed issues of access to justice and discrimination in many areas of American life. SALT has organized and published important studies of legal education and access to justice, and has conducted numerous national conferences and programs designed to help people in American legal education grapple with these issues. In October 1993 the SALT Board of Governors authorized the creation of a special committee to work on access to justice issues within health care reform, and we are pleased to have enlisted the participation of many of the leading American law professors who analyze the organization and delivery of health care services.

This testimony, necessarily prepared under tight time

constraints, represents the beginning of a larger and ongoing effort. The access to justice and discrimination issues raised by the Health Security Act are numerous and complex. The members of the SALT Committee, listed below, are willing and committed to working with the Administration and the Congress to help devise just and effective responses to these difficult issues.

The Health Security Act: Goals and the Challenge of Implementation

SALT strongly supports the Health Security Act's ambitious pro-consumer goals. We agree with the White House Domestic Policy Council that "[t]he system should avoid the creation of a tiered system[,] providing care based only on differences of need, not individual or group characteristics," and that "fair and open democratic procedures should underlie decisions concerning the operation of the health care system and the resolution of disputes that arise within it."¹

These admirable principles will encounter resistance. Economic and budgetary pressures create strong incentives to avoid serving the higher-cost and/or currently uninsured patients whom the Act is designed to protect. Bureaucracies created by insurance companies, providers, and government agencies have historically operated with little consumer input and have systematically failed

¹ White House Domestic Policy Council, The President's Health Security Plan 11, 13 (N.Y. Times Books, E. Eckholm ed., 1993).

to enforce provisions meant to protect vulnerable groups.² A long tradition of inadequately-funded, inferior, and segregated services for low-income and minority patients remains entrenched by widespread racial, gender, ethnic, and class bias in many parts of the system.³

Against this background, it is virtually certain that the goals of equal access, quality assurance, and fair procedures will come under serious attack. Whatever the shape of the national health reform law as enacted by Congress, many levels of government and the health care industry will play a large role in further defining the meaning of rights and remedies through regulations and on-the-ground operations. Justice and legal process issues will

² See, e.g., Rand E. Rosenblatt, "The Courts, Health Care Reform, and the Reconstruction of American Social Legislation," 18 J. Health Politics, Policy & Law 439 (1993) (discussing the Boren Amendment and other legislation); Sidney D. Watson, "Health Care in the Inner City: Asking the Right Question," 71 N. C. L. Rev. 1648, 1666-1671 (1993) (discussing Title VI of the 1964 Civil Rights Act); Sylvia A. Law, Blue Cross: What Went Wrong? (Yale Univ. Press, 2nd ed., 1976) (discussing the role of Blue Cross as Medicare intermediary); Rand E. Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 88 Yale L.J. 243 (1978) (discussing the Hill-Burton Act, Medicaid, and national health planning); Elizabeth Jameson & Elizabeth Wehr, "Drafting National Health Care Reform Legislation to Protect the Health Interests of Children," 5 Stanford Law & Policy Rev. 152, 166-68 (1993) (discussing coverage provisions of the federal HMO Act).

³ See, e.g., Watson, supra note 2; Jane Perkins, "Race Discrimination in America's Health Care System," 27 Clearinghouse Rev. 371 (Special Issue 1993); Mark Schlesinger, "Paying the Price: Medical Care, Minorities, and the Newly Competitive Health Care System," 65 Milbank Q. 270 (1987); David Barton Smith, "The Racial Integration of Health Facilities," 18 J. of Health Politics, Policy and Law 851 (1993); Council on Ethical and Judicial Affairs, AMA, "Black-White Disparities in Health Care," 263 JAMA 2345 (1990); Kenneth C. Goldberg et al., "Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for All 1986 Medicare Patients," 267 JAMA 1473 (1992).

play an important role in the struggle to define and implement health care as a right "that cannot be taken away."

Building on what is already in the Health Security Act, we propose three systems of rights and remedies to help achieve the Act's important goals: (1) individual claims through an administrative process; (2) private rights of action in federal and state courts; and (3) organized consumer advocacy at all levels of the system.. After discussing these approaches, we also present comments on two other matters relating to justice and health care reform: (4) privacy of the personal information generated by the system, and (5) medical malpractice reform.

(1) Individual Claims

The reformed health care system, like the system that exists today, will generate millions of claims and disputes. Particularly in the early years, decisions resolving these disputes serve a valuable function in defining and stabilizing standards and practices regarding coverage, copayments, "necessary or appropriate care," (sec.1141(a)) and other matters. It makes sense, from everyone's point of view, that these claims be adjudicated as much as possible in an administrative process, rather than in state or federal courts. However, serious commitment to a fair and effective process, as well as concern to minimize the numbers of claims adjudicated in the courts, requires careful attention to assure that the administrative process is fair and effective. As currently written, Title V, Subtitle C, Part I of the Act provides

significant protections for individuals seeking redress for denied benefits, but it also omits important provisions necessary to provide fully effective avenues of relief.

(a) Access to Claims and Appeals: (i) defining a "claim," (ii) triggering an individual's right to notice that an adverse decision has been made, and (iii) to notice that an appeal system exists. As the Act is currently written, the entire claims system begins with an individual patient filing a "claim" with a health plan for "payment" or "provision" (including preauthorization) of services. Section 5201(a)(1). Submission of such a claim to a health plan "in complete form" then triggers a duty on the plan to notify the patient within 30 days of its disposition, including specific reasons for a denial and, if applicable, a description of necessity/appropriateness guidelines and of the process used in making the determination, together with notice of the right to appeal. Sections 5201(b)(1), 5201(e). "Urgent requests for preauthorization" must be acted upon within 24 hours, or the plan is deemed to have approved the claim. Section 5201(c).

While these provisions protect participants in traditional insurance plans, they are not adequate for the millions of patients who have enrolled, and whom the Act encourages to enroll, in HMOs and other capitated managed care plans. In these settings, patients do not typically submit "claims" for services already received, and "pre-authorization requests" may apply to only a limited number of services. Rather, patients' explicit or implicit requests for services will occur primarily in discussions

with individual health care providers, whose response may be influenced by practice guidelines and financial incentives structured by the plan.⁴ If providers do not inform patients that certain service options are or might be helpful, patients will not likely be able to submit a claim regarding them. Utilization management guidelines and/or financial incentives may also lead to the termination or reduction of a course of treatment, including hospitalization, nursing home care, or home health services, without the patient being clearly aware that a coverage decision has been made.

Effective procedures for reviewing these low-visibility decisions to deny or reduce care are essential for patient well-being and equity of treatment. This is because the increasing efforts by payors (including HMOs) to influence the care of individual patients are diverse, changing, and the subject of vigorous debate. As the 1989 Institute of Medicine (IOM) study of utilization management put it, "we find a series of working hypotheses and partial solutions that are continually revised, discarded, and even reinvented as changes occur in medical technology, social values, economic conditions, and other

⁴ See, e.g., Bradford H. Gray, The Profit Motive and Patient Care 228-233 & passim. (1991) (reviewing wide range of financial incentives and noting that "What is clear . . . is that the arrangements in some plans create some very strong disincentives against physicians' making patient care decisions (regarding hospitalization, diagnostic services, specialist referrals) that would cost the plan money.")

circumstances."⁵ Insurance contracts typically use terms such as "medically necessary" and "experimental treatment" without clear definition, there is no authoritative national body to clarify their meaning, and their proper application in individual cases is hotly disputed.⁶ Moreover, the Institute of Medicine study found that in 1989, "[s]ystematic evidence about the impact of utilization management methods on the quality of care and on patient and provider costs is virtually nonexistent."⁷ Given the wide variety of criteria, incentives, training, supervision, and implementation methodologies found, the Institute of Medicine recommended, inter alia, that utilization management criteria (including those used by hospitals and HMOs) should be available

⁵ Institute of Medicine, Committee on Utilization Management by Third Parties, Controlling Costs and Changing Patient Care? The Role of Utilization Management 1 (Bradford H. Gray & Marilyn J. Field, eds., 1989) (hereinafter cited as IOM Study).

⁶ Compare Fuja v. Benefit Trust Life Insurance Co., 809 F. Supp. 1333 (N.D. Ill. 1992) (finding high dosage chemotherapy with autologous bone marrow transplant (HDC/ABMT) a covered treatment for breast cancer) with Farley v. Benefit Trust Life Insurance Co., 979 F.2d 653 (8th Cir. 1992) (finding HDC/ABMT to be not a covered treatment for skin cancer). See also Spain v. Aetna Life Insurance Co., 11 F.3d 129 (9th Cir. 1993) (insurance company approves ABMT for treatment of testicular cancer and patient undergoes first two stages of treatment; company then withdraws approval for third stage of treatment, then reverses itself again and approves third stage after notification of lawsuit by patient; wrongful death action based on effects of delay in treatment held preempted by ERISA); Associated Press, "\$90 Million Lawsuit Cuts to the Core of Managed Care Debate; Critics See the Case as an Example of Cost Obsession; Cancer Patient Dies after her HMO Refused to Pay for an Expensive Treatment," Los Angeles Times, Feb. 7, 1994, at p.D4:1 (summarizing Nelene Fox v. Health Net and quoting officials of other HMOs to the effect that companies make exceptions to guidelines for "business reasons" not related to medical outcomes).

⁷ IOM Study at 4. See also Marc A. Rodwin, Medicine, Money, and Morals 163 (1993).

for outside scrutiny by physicians, purchasers, and patients, and that a system for patients and physicians to appeal utilization management decisions "is an essential protection for patients."⁸

PROPOSED CHANGES:

The Health Security Act, as currently written, does not provide an adequate and realistic claims and appeals process because it does not create a realistic entry-point into the system. The entry-point or trigger cannot be based solely on the patient taking action to "file a claim," because it may not be clear to the patient that an adverse decision has been made or a guideline or incentive applied. Rather, the appeals process must also be triggered by the action of the plan itself. Building on the concept of an "initial determination" contained in the current Medicare regulations regarding HMO services for Medicare beneficiaries, see 42 C.F.R. sec.417.606 (1992),⁹ the Health

⁸ IOM Study at 6 (emphasis supplied).

⁹ @ 417.606 Initial determinations.

(a) Actions that are initial determinations. An initial determination is a determination made by an organization, or carrier or intermediary acting for the organization, concerning the rights of an enrollee with regard to services payable by Medicare that are furnished by the organization. In addition, an initial determination is also any determination made with respect to--

- (1) Reimbursement for emergency or urgently needed services;
- (2) Any other health services furnished by a provider or supplier other than the organization that the enrollee believes--
 - (i) Are covered under Medicare; and
 - (ii) Should have been furnished, arranged for, or reimbursed by

Security Act should require health plans to notify plan participants of an adverse initial determination whenever:

1. the plan terminates or reduces a course of treatment during an ongoing series of services, such as hospital, nursing home, rehabilitation, or home health services;

2. the plan declines to provide a service requested orally or in writing by the participant (or on his/her behalf); or

3. an individual participant expresses dissatisfaction orally or in writing with the type or extent of services being provided by the plan.¹⁰

To be effective, the notice triggered by an initial determination or claim denial must take into account the participant's need for information and possibly for assistance.

Statutory language implementing these principles is as follows:

Section 5201. HEALTH PLAN CLAIMS AND APPEAL PROCEDURE.

(a) DEFINITIONS. --- For purposes of this section --

[retain existing sections (1), (2), and (3)]

(4) The term "initial determination" means --

the organization.

(3) The organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the organization and the enrollee has not received the services outside the organization.

¹⁰ See The Center for Medicare Advocacy, "Position Paper on the Remedies and Enforcement Provisions in HR 3600/S 1757," available from Congressional Consultants, 711 Second St., Suite 300, Washington, DC 20002.

(A) a decision by a health plan (including any person acting on its behalf) to terminate or reduce a course of treatment during an ongoing series of services, including, but not limited to, hospital, nursing home, rehabilitation, or home health services;

(B) a decision by a health plan (including any person acting on its behalf) to deny or not to provide a service requested orally or in writing by the plan participant (or on his or her behalf);

(C) a decision by a health plan (including any person acting on its behalf) to deny, reduce, or not pay for emergency or urgently needed services, and any other health services furnished by a provider or supplier other than the health plan that the plan participant believes--

(i) Are covered under the health plan; and

(ii) Should have been furnished, arranged for, or reimbursed by the health plan.

(D) a decision by a health plan (including any person acting on its behalf) to deny or not to provide a service that a participant believes should be furnished or arranged for by the health plan.

(5) The term "informal initial determination" means a decision by a health plan (including any person acting on its behalf) not to resolve in favor of a plan participant a participant's expression of dissatisfaction orally or in

writing with the type or extent of services being provided by the plan.

(b) GENERAL RULES GOVERNING TREATMENT OF INITIAL DETERMINATIONS AND CLAIMS. ----

(1) In any case in which a health plan (including any person acting on its behalf) makes an initial determination, the plan shall provide to the plan participant and to any affected provider written notice -

(A) that an initial determination has been made and the specific reasons for that decision, including any information required by subsection (e);

(B) that a system for reviewing determinations and claims exists both within and outside the health plan, and the names, addresses, and telephone numbers needed to access that system;

(C) that a system for assisting patients in the process of reviewing determinations and claims exists, and the names, addresses, and telephone numbers needed to access that system, including, at a minimum, those of the office of the ombudsman established pursuant to section 1326;

(D) that to have their request or claim considered fully, it is advisable for participants to submit supporting information, and that assistance in doing so is available as noted in subparagraph (C).

(2) In any case in which a health plan (including any person acting on its behalf) makes an informal initial determination, the plan shall provide to the plan participant written notice --

(A) that a system for reviewing determinations and claims exists both within and outside the health plan, and the names, addresses, and telephone numbers needed to access that system;

(B) that a system for assisting patients in the process of reviewing determinations and claims exists, and the names, addresses, and telephone numbers needed to access that system;

(3) Notices to individual plan participants --

(A) shall be written in language that can be understood by a typical individual participant;

(B) shall provide for access to the information by individuals whose primary language is not English;

(C) shall be accompanied by an oral version of the information, and an offer of more assistance for people who have difficulty understanding the written notice.

(b) The Ombudsman Office, Lay Advocates, and Medical Expertise for Consumer/Participants

Physicians have traditionally acted as advocates for their patients in dealing with coverage and reimbursement issues.¹¹

¹¹ See, e.g., cases cited in notes 6 & 17.

However, as third party utilization management and review has become more widespread and aggressive, there has been a "reportedly high level of physician compliance with determinations of utilization managers."¹² At the same time, and disturbingly, "almost one-third of the physicians who responded to a 1988 AMA survey said that they had patients who had suffered an aggravation of an illness or injury as a result of delays or denials in a prior-authorization process."¹³

The Act recognizes that physicians' opinions are vital evidence in the resolution of many claims and disputes. See Sec. 5201(b)(4)(C) (requiring the plan itself to rely on qualified physicians to resolve medical issues raised by claims). However, enrollees in managed care plans ordinarily have coverage only to see physicians associated with the plan. "Current experience with Medicare HMOs is that plan physicians will not offer evidence that contradicts their plan or employer's decision to deny a service."¹⁴ While some patients may be able to pay an out-of-plan physician for a second opinion out of their own funds, and later hope to re-coup such costs in the event of a successful appeal

¹² Bradford H. Gray, supra note 4, at 309. Gray quotes one medical journalist as reporting that when utilization review companies determine that further hospital care is not medically necessary, "[i]n almost all cases, the attending physician will discharge the patient" Id.

¹³ Id. at 303.

¹⁴ "Proposed Revisions to Health Care Reform Act," p.1, submitted to Office of Health Legislation, DHHS, by Sally Hart Wilson, Esq., Center for Medicare Advocacy, Inc., Tucson AZ, (602) 577-4611, and Alfred J. Chiplin, National Senior Citizen's Law Center, 11/4/93.

(section 5204(d)(2)(iv), most low- and moderate income patients will not be able to afford such an up-front expense, with only a contingent and delayed hope of later recovery, and thus many meritorious claims would be foreclosed.

The integrity of the claims process requires a source of advocacy assistance for participants, so that they can understand the process, present their claims appropriately and effectively, and have access to medical expertise where needed. For cases involving large amounts of money and a high likelihood of success, post-litigation attorney's and expert's fees may be an adequate and appropriate source of financing. However, millions of claims and disputes will not involve large amounts of money, but will be of vital importance to participants. The most efficient way of providing such assistance would be through a system of qualified non-attorney advocates, backed by legal and medical expertise.

A logical location for these advocacy services already in the Health Security Act is the office of the ombudsman. According to sec.1326(a), "[e]ach regional alliance must establish and maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and the alliance." These offices could train and employ non-attorney advocates, organize and pay for appropriate medical expertise, and assist the private bar (through continuing legal education) in representing consumers. Following the precedent in some Medicaid managed care programs, the ombudsman office could also contract with independent groups for

individual and group advocacy.¹⁵ Similar agencies and practices already exist in the form of nursing home ombudsmen, protection and advocacy agencies for the developmentally disabled and mentally ill, and legal services programs, public defenders, and consumer or public advocates.

PROPOSED CHANGES:

The ombudsman offices should be explicitly authorized to carry out the important advocacy and assistance functions noted above; their independence should be guaranteed; and adequate funding must be assured. As currently written, the Act allows states the option of permitting consumers to designate one dollar of the premium paid for the operation of the ombudsman's office, section 1326(b), while not requiring or prohibiting additional funding. Since premiums are paid on behalf of families, such a system might generate (for example) \$500,000 in a metropolitan area of 1.5 million people -- enough to fund only a few advocates and support staff, and not nearly enough to carry out the needed functions. Formulae for adequate funding should be developed based on existing norms for legal services and other advocacy programs, and should be expressed as a percentage of premiums or as a dollar figure per individual in the alliance population, in order to reflect realistically the numbers of participants being served.

¹⁵ See Rand E. Rosenblatt, "Medicaid Primary Care Case Management, The Doctor-Patient Relationship, and the Politics of Privatization," 36 Case Western L. Rev. 915, 964 (1985-86) (reporting on contract between state Medicaid agency and advocacy group to monitor and improve consumer experience with managed care).

As currently written, the Health Security Act requires regional alliances, but not corporate alliances, to establish an ombudsman office. See sec. 1326. The apparent assumption that employees of large employers need less assistance than other consumers is not warranted by experience. Some of the most egregious denial of coverage and restriction of benefits cases have arisen from self-funded employer health benefit plans.¹⁶ The relatively small permissible size of corporate alliances (as low as 5,000 employees, with lower limits under active discussion) as compared with regional alliances will make many corporate alliances even more vulnerable to cost pressures to deny care than many regional alliances. Finally, the Act properly channels participant complaints against health plans offered by corporate alliances to the state complaint review offices attached to the regional alliance in whose geographic area the corporate alliance operates and the employee resides. Section 5202(a)(1). It would be logical and efficient to refer corporate alliance consumer/participants to the ombudsman office in the same regional alliance in which the complaint would be heard, and require corporate alliances to make the appropriate financial contribution to that office. The Act

¹⁶ See Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied, 113 S.Ct. 812 (1992) (utilization review company under contract to South Central Bell Telephone Company denies coverage for requested hospitalization for patient with high-risk pregnancy), discussed in subsection (d) below; McGann v. H. & H. Music, 946 F.2d 401 (5th Cir. 1991), cert. den. sub nom. Greenberg v. H. & H. Music, 113 S.Ct. 482 (1992) (self-insured employer's reduction of lifetime maximum medical benefits from \$1 million to \$5,000 for AIDS-related claims only, after employee had filed AIDS-related claim, upheld as legal under ERISA).

should be amended to require corporate alliances to establish their own independent ombudsman offices or to contract with and financially support the ombudsman offices in the regional alliances in which they operate and in which their employees reside.

(c) Independence for persons administering the claims process.

Appeals of plan denials are to be heard by hearing officers "employed by the State in the [Complaint Review] office [established by the State for each Regional Alliance]," secs.5204(a)(1), 5202(a)(1). Given the complexity and novelty of this administrative structure, it is essential that state hearing officers have federal statutory protection for their independence of judgment, while also being able to develop the necessary expertise. States should be required to provide full-time employee hearing officers with protections equivalent to or similar to those provided federal Administrative Law Judges (ALJs) or their state administrative equivalents, if such state protections exceed federal standards. For similar reasons, the members of the Federal Health Plan Review Board (sec.5205) should have terms of office and other protections equivalent to those provided for the National Labor Relations Board (NLRB).

(d) Adequate Remedies for Health Plan Negligence and Repeal of the ERISA Preemption of State Tort Law. Increasingly aggressive preauthorization, utilization review, and financial incentives in health care can lead to serious patient harm and even death.¹⁷

¹⁷ See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied, 113 S.Ct. 812 (1992) (utilization review company denies coverage for requested

In Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), a pregnant patient's obstetrician classified her as a high risk pregnancy and recommended complete bed rest and eventual hospitalization. 965 F.2d at 1322-23. Despite extensive advocacy by the obstetrician, a prior high risk pregnancy by the same patient, and concurrence by a employer-solicited second medical opinion, see *id.*, the employer's utilization review subcontractor, United Healthcare, Inc. "determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care." 965 F.2d at 1324. "During a period when no nurse was on duty, the fetus went into distress and died." *Id.* The Corcorans brought a wrongful death action under state law against United Healthcare, alleging that various acts of negligence in responding to their request for services led to the death of their unborn child. *Id.*

These facts call out for some external review of how utilization management operated in this case. Perhaps United Healthcare had good reasons for its decision to deny authorization

hospitalization for patient with high-risk pregnancy; after death of fetus allegedly caused by denial of hospitalization, court holds that federal ERISA law preempts state tort law and provides no compensatory relief); in accord, Kuhl v. Lincoln National Health Plan of Kansas City, Inc., 999 F.2d 298 (8th Cir. 1993) (preauthorization for heart surgery delayed, patient dies, ERISA preempts state tort law); Spain v. Aetna Life Insur. Co., 11 F.3d 129 (9th Cir. 1993) (wrongful death action based on insurance company's withdrawal (and subsequent reinstatement) of previously granted authorization for procedure preempted by ERISA); Wickline v. State of California, 192 Cal.App.3d 1630, 239 Cal. Rptr. 810 (1986) (hospitalization extension authorized for only 4 instead of requested 8 days; patient loses leg after post-operative complications).

for a hospital stay. Perhaps Mrs. Corcoran's obstetrician failed to present her case effectively to the reviewers. Perhaps United's reviewers were inadequately qualified, trained or supervised, or perhaps its criteria were too inflexible. But these questions will never even be explored, much less answered, in a court of law. This is because, following Supreme Court precedent, the federal courts have overwhelmingly held that when health coverage is derived from employment (as most health coverage is), the ERISA statute (see 29 U.S.C. sec.1144(a)) preempts state tort law with respect to suits against health benefit plans and their utilization review subcontractors, and that ERISA itself provides no compensatory damages.¹⁸ In denying any remedy for negligently-caused injury in the Corcoran case, the Fifth Circuit Court of Appeals conceded that ERISA "leaves a gap in remedies within a statute intended to protect participants in employee benefit plans"¹⁹ Given how little is known about the impact of utilization management on quality of care, the lack of industry and professional standards regarding quality assurance and utilization management, and the strong financial incentives to deny coverage and services, the remedial vacuum created by ERISA and its judicial interpretation is shockingly irresponsible.

As currently written, the Health Security Act maintains the ERISA preemption of state law for plans offered by corporate alliances, and appears to reduce the already inadequate federal

¹⁸ See, e.g., Corcoran and Kuhl, supra note 5.

¹⁹ Corcoran, 965 F.2d at 1333.

remedies under ERISA. First, the Health Security Act confirms that ERISA's preemption provision, section 514(a) of the ERISA Act, 29 U.S.C. sec.1144(a), will continue to apply to group health plans maintained by corporate alliances. See Health Security Act section 8402(a)(3) (adding new section (c)(5) to section 4 of the ERISA Act, 29 U.S.C. sec.1003). Second, the Health Security Act specifies that the administrative claims procedure set out in sections 5202 through 5205 "shall be the exclusive means of review" for corporate alliance health plans. Sec.5202(d). The Act explicitly forecloses corporate alliance consumers from access to state and federal courts, sec.5203(a)(1), except that Federal Health Plan Review Board decisions in cases arising out of corporate alliances can be reviewed by federal courts of appeal when the amount in controversy exceeds \$10,000. Sec.5205(e)(1).

These provisions perpetuate the remedial gap noted in the Corcoran opinion, because the Health Security Act's administrative remedies include only provision of benefits due under the plan,²⁰ with no provisions for compensatory or punitive damages. Sec.5204(d)(2). Moreover, access to federal courts for corporate alliance consumers is even more restricted than is now the case under ERISA. Under current ERISA law, beneficiaries of employee health benefit plans can sue in federal district court without regard to amounts in controversy or exhaustion of administrative

²⁰ Remedies also include pre-judgment interest on amounts spent, and attorney's fees, expert witness fees, and other reasonable costs relating to the hearing and subsequent appeals, as well as cease-and-desist orders (secs. 5204(d)(2), 5205(g)).

remedies, see 29 U.S.C. secs.1132(a), (e), (f), and in many cases can obtain de novo judicial review. Under the Health Security Act, these same beneficiaries will have to exhaust administrative remedies, may be foreclosed from all judicial review by the \$10,000 amount-in-controversy requirement, and if they can obtain judicial review, will presumably receive it only under a "supported by the record" or "substantial evidence" standard.

Finally, the Health Security Act lacks protections or substantive standards regarding utilization management criteria and financial incentives. In the absence of such standards, access to state and federal courts, and particularly to state tort law, is essential to guard against what one state court termed "defects in the design or implementation of cost containment mechanisms, as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden."²¹ The Health Security Act provides for complaints against health plans that deny or delay "payment or provision of benefits under the plan." Sec.5202(b)(1). Artful drafting might create "plans" that themselves were defective in design, yet such defects might be insulated from any administrative or judicial review.

The inadequacy of consumer remedies for members of corporate alliances is especially disturbing because numerous press reports have stated that reduction of the current 5,000 employee minimum is

²¹ Wickline v. State of California, 228 Cal.Rptr. 661, 670-71 (Cal. App.1986), petition for review dismissed, 239 Cal.Rptr. 805, 741 P.2d 613 (1987).

being widely discussed in Congress and the Administration. If this minimum is reduced, ever higher percentages of the population will be enrolled in corporate alliances, with extremely weak protections for quality of care against the cost containment pressures that have dominated the health reform debate.

PROPOSED CHANGES

To guard against all of the above problems, and provide adequate consumer protection for consumers in corporate alliances, the "exclusive means of review" in sections 5202(d) and 5203(a)(1) should be deleted, and the ERISA preemption provision, 29 U.S.C. sec.1144(a), should be repealed. Consumers in corporate alliances should have at least the same rights and protections as the general population, supplemented by whatever collective bargaining arrangements or other protections are also in place.

(e) \$10,000 amount in controversy requirement for access to federal courts. A system as complex as national health reform is likely to generate many important disputes about statutory and regulatory interpretation that should be resolved by the federal courts. Many of these questions may arise in cases where the claim benefits do not amount to \$10,000, although the questions at stake may be quite significant. Congress recognized this truth when it eliminated the \$10,000 amount-in-controversy requirement for

federal question jurisdiction in 1980.²² As the Senate Judiciary Committee then observed,

The amount in controversy requirement is particularly troubling in that it falls disproportionately on the poor since their claims tend to be small in absolute dollar terms. It operates in total disregard of the importance, difficulty or far-reaching nature of the Federal issues raised. It ignores the fact that it is virtually impossible to put a monetary value on many important constitutional and Federal statutory rights.²³

The Act's \$10,000 requirement, sec.5205(e), should be lowered to \$1,000 and review allowed in federal district courts, as is now the case with Medicare claims. In addition, the Act should allow aggregation of claims with common questions of law so that important issues are not foreclosed from federal judicial review.

(f) Burden of proof and Hearing Officer Expansion of the Record. Hearing officers are supposed to decide cases on the preponderance of the evidence (sec. 5204(d)), but the Act does not specify who has the burden of proof or persuasion. The Act should be amended to clearly put the burden of proof on the health plan

²² Federal Question Jurisdictional Amendments Act of 1980, Pub. L. No. 96-486, 94 Stat. 2369 (1980) (amending 28 U.S.C. sec.1331).

²³ Federal Question Jurisdictional Amendments Act of 1980, Rpt. of the Sen. Judiciary Comm., 96th Cong., 2d Sess.. Rpt. 96-827, June 20, 1980.

seeking to deny the claim, because of its superior resources and information. The Act should also be amended to authorize and require hearing officers to expand the record on their own initiative, so as to ensure that substantively correct decisions are rendered. Many patients may not have the skills and/or resources to present their case, and decisions should not be made against patients on the basis of default or an incomplete record.

(g) Review of emergency claims. Expedited hearing officer decisions on urgent pre-authorization requests are not subject to review by the Federal Health Plan Review Board (FHPRB), even in cases of denial of the request (section 5204(e)(2)). Such denials may involve life- or health-threatening situations²⁴, and therefore should be subject to expedited FHPRB review.

(2) Private Rights of Action

(a) Private Rights of Action Against Federal Officials

Many federal agencies, notably the departments of Health & Human Services (HHS) and Labor, and the new National Health Board, will play a large role in defining the details of the new health care system and in enforcing its rules and standards. Even assuming good faith and sincere commitment on the part of federal officials, political common sense tells us that in performing their roles, these agencies will face many of the same political and

²⁴ See cases cited in notes 6 and 17 supra.

budgetary pressures that are currently affecting the Administration and Congress. The history of health care reform clearly teaches that the interests of patients, who face tremendous costs in gathering information and organizing collective action, are often underprotected in the federal administrative process.

Three examples illustrate the importance of providing clear rights and remedies against federal officials. First, after Medicaid was enacted in 1965, HEW -- even under the initial leadership of President Lyndon Johnson and Secretary John Gardner -- did not require hospitals that had received federal Hill-Burton construction funds, and had therefore undertaken obligations of nondiscrimination and community service, to accept federally-funded Medicaid patients. This major barrier to equal care for the poor and minorities (also a likely violation of Title VI of the 1964 Civil Rights Act) was not prohibited by federal regulation until 1974, and then only after the HEW Secretary was ordered to do so by a federal judge.²⁵

Second, consider the important question of federal and state enforcement of quality of care standards for Medicaid patients in nursing homes. For years the surveys required by Secretary of HHS focused almost exclusively on facilities and paper records, rather than on patient care itself, until the Tenth Circuit Court of Appeals ruled that the Secretary "has a duty to . . . adequately inform herself" on a continuing basis about the realities of

²⁵ See *Cook v. Ochsner Foundation Hospital*, 61 F.R.D. 354, 360 (E.D. La. 1972), and other cases discussed in Rosenblatt (1978), supra note 2 at 278-79 & 264-286.

patient care.²⁶ Third, although Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) in April, 1986 (also known as the "COBRA antidumping amendment"), 42 U.S.C. sec.1395dd, effective August 1, 1986, requiring hospitals participating in Medicare to provide emergency treatment to all patients who needed it, as late as December 1986 the Health Care Financing Administration (HCFA) had not even communicated with its own Regional Administrators regarding implementation of the law.²⁷

Congress can no longer rely on the federal courts to take the initiative in remedying administrative nonenforcement of health care reform. The courts, notably the Supreme Court under Chief Justice Rehnquist, have made it clear that they will not enforce rights and remedies on behalf of federal program beneficiaries unless explicitly ordered to do so by Congress.²⁸ Judicial review of federal agency action and inaction is generally governed by the federal Administrative Procedure Act, 5 U.S.C. sec. 701 et seq., and here too the Supreme Court has sharply restricted the ability of affected parties to obtain judicial relief.²⁹

²⁶ Estate of Smith v. Heckler, 747 F.2d 583, 589 (10th Cir. 1984).

²⁷ See House Committee on Government Operations, Equal Access to Health Care: Patient Dumping, H. R. Rep. No.531, 100th Cong., 2d Sess. (1988).

²⁸ See Suter v. Artist M., 112 S.Ct. 1360 (1992), discussed in Rosenblatt (1993), supra note 2 at 462-474, and in subsection 2(b)(i) below.

²⁹ See, e.g., Heckler v. Chaney, 470 U.S. 821 (1985) (challenges to agency failures to enforce the law in individual cases are presumptively nonreviewable; Lujan v. Defenders of Wildlife, 112 S.Ct. 2130 (1992) (tightening standing requirements

PROPOSED CHANGES:

The Act currently provides no explicit consumer rights of action against federal officials, except in the rare event that the Secretary of HHS is operating a regional alliance directly after a state failure to qualify under the Act. (Sec. 5236). To create effective consumer rights with respect to federal agencies, the Act should be amended to include the following provisions:

(a) The United States District Court for the District of Columbia shall have jurisdiction, without regard to amount in controversy, over lawsuits challenging (1) a federal agency's failure to promulgate on time any regulations required by this Act to be promulgated, (2) a federal agency's failure to promulgate, on petition, any regulations that may prove necessary for the efficacious implementation of this Act, or (3) a pattern or practice of a federal agency's failure to enforce this Act or its regulations.

(b) A federal agency's failure to issue regulations shall be deemed reviewable:

(1) in the case of regulations required by this Act to be promulgated by a date certain, once that date has passed without the promulgation of a final rule; and

(2) in the case of other regulations, at the earliest of the following dates: (A) once

under the federal APA)

the agency has rejected a written petition for rule making or otherwise indicated in writing its intention not to issue the requested rule, (B) 90 days after the filing of a petition for rule making if no notice of proposed rule making has been issued, or (C) 180 days following the issuance of a notice of proposed rule making, if no final rule has been issued.

(c) A federal agency's failure to enforce this Act or regulations promulgated under this Act shall be deemed reviewable once the agency has rejected a written request for enforcement or 90 days after the filing of such a request if no enforcement activity has been undertaken.

(d) Any person aggrieved by a federal agency's failure to promulgate regulations under this act or by its failure to enforce this Act or regulations promulgated under this Act shall have the right to challenge such failure. In an action challenging the agency's failure to promulgate regulations, a "person aggrieved" shall be any person whose rights, responsibilities, obligations, or entitlements under this Act would likely be clarified, or whose interests under this Act would likely be further protected, by the issuance of the regulation(s) at issue. In an action challenging the agency's failure to enforce this Act or regulations promulgated under this Act, a "person

aggrieved" shall include (a) any person who prima facie has been injured by the failure of another person to fulfill obligations imposed by the Act or such regulations which are allegedly not being enforced, (b) or any person who belongs to a group on whose behalf the agency exhibits a pattern of failing to take enforcement action.

(e) The term "federal agency" shall mean the Department of Health and Human Services and the Department of Labor, and the Secretaries thereof and their designates, the National Health Board, the Federal Health Plan Review Board, and any other federal agency, entity, or official having responsibilities under this Act.

(b) Private Rights of Action Against Non-Federal Actors

In anticipation of enforcement and implementation problems, the Health Security Act establishes federal private rights of action against states (sec.5235) and regional and corporate alliances (sec.5237) who fail to carry out their responsibilities under the Act. The Act also creates a federal private right of action against health plans (sec.5238) who fail to comply with sec. 1402(c), which prohibits health plans from discriminating in purpose or effect on the basis of race, national origin, sex, language, socioeconomic status, disability, health status, or anticipated need for health services. These provisions are

commendable. However, a number of important improvements are needed.

(i) The "Suter Problem"

From the early 1970s until the early 1990s, the federal courts usually permitted the beneficiaries of federal statutes to judicially enforce their provisions against state agencies even without explicit statutory language literally declaring that beneficiaries had certain "rights."³⁰ Justice Brennan, writing for a five-justice majority in Wilder v. Virginia Hospital Association, 110 S.Ct. 2510 (1990), explained that the proper method of statutory interpretation was not to search for magic words such as "right" or "cause of action," but rather to inquire whether the statute created a "binding obligation" on a government agency to do something. If so, and if that obligation was intended to benefit the party seeking to enforce it, then that party (in this case, hospitals) had a federal right under the statute and a federal cause of action under 42 U.S.C. sec.1983, unless the opposing party (in this case, the state agency) could show, by clear evidence, that Congress did not intend to create enforceable rights or had foreclosed enforcement under 42 U.S.C. sec.1983.³¹

In 1992, after the retirement of Justices Brennan and Marshall, and the appointment of Justices Souter and Thomas, the

³⁰ See generally Rosenblatt (1993), supra note 2.

³¹ See Rosenblatt (1993), supra note 2, at 459-60; Rand E. Rosenblatt, "Statutory Interpretation and Distributive Justice: Medicaid Hospital Reimbursement and the Debate Over Public Choice," 35 St. Louis Univ. L. J. 793, 801 (1991).

Supreme Court revisited this issue. In Suter v. Artist M., 112 S.Ct. 1360 (1992), a new majority, in an opinion by Chief Justice Rehnquist, held that a statutory funding requirement that child protection agencies make "reasonable efforts" to prevent the removal of children from their homes was not sufficiently clear in its language to create an enforceable right under sec.1983, or that if it did, the "right" was only to have the state file the appropriate forms with the federal government, which had been done. Although Wilder was technically not overruled, the Supreme Court has adopted a new approach to interpreting federal statutes that could undercut the enforceability of many of the responsibilities created by the Health Security Act.³²

As currently written, the Health Security Act commendably attempts to deal with this problem. Section 5235 provides that a state's failure to carry out an applicable statutory responsibility "constitutes a deprivation of rights secured by this Act for the purposes of . . . [42 U.S.C. sec.1983]," and that courts can exercise jurisdiction without regard to administrative or other remedies. Sections 5236, 5237, and 5238 confer similar (but not identical) rights of action against federally-operated alliances, regional and corporate alliances, and health plans.

PROPOSED CHANGE:

³² See, e.g., Evelyn V. v. Kings County Hospital, 819 F.. Supp. 183 (E.D.N.Y. 1993)(holding, on the basis of Suter, that numerous federal statutes and regulations regulating quality of care in the Medicaid program did not create enforceable federal rights on behalf of patients against a public hospital or local government).

These provisions effectively override the strong presumption in Suter and its predecessor, Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981), that Congress did not intend to create enforceable rights. However, these provisions do not speak to the other dimension of Suter: that the rights created may be perceived by the Supreme Court as formalities, requiring the obligated entity to do no more than file a paper with the appropriate statutory words. To avoid this kind of interpretation, the following provision should be added to the Act:

In an action brought under sections 5235, 5236, 5237, 5238 or 5240 [or under the above proposed section creating private rights of action against federal agencies], the provisions of this Act creating responsibilities or duties on the part of federal agencies, states, health alliances, health plans, or any other entity shall be considered judicially enforceable substantive requirements unless the language, structure, and legislative history of the Act clearly indicate the contrary. Statutory provisions requiring an entity to submit information, plans, certifications, assurances, and the like to another entity shall not be construed as precluding enforcement of substantive provisions regarding such submissions.

(ii) The Problem of Discrimination

Race, color, national origin, sex, sexual orientation,

language, socioeconomic class, age and disability all affect the accessibility and adequacy of health care. Discrimination, although often subtle and even unintentional, nonetheless pervades the health care industry.³³ The true depth of discrimination is actually unknown because agency monitoring and enforcement of civil rights compliance by federally subsidized health providers has, at best, been deficient.³⁴ Nevertheless, available information from state Medicaid reports, private research, and an abundance of anecdotal information amply document the seriousness of provider discrimination that contributes to the shocking disparities in health status.³⁵

While the Health Security Act contains a number of helpful antidiscrimination provisions, important improvements need to be made.

³³ See, e.g., sources cited in note 3 *supra*. See also Testimony of Dr. William Gibson of the National Association for the Advancement of Colored People before the Subcommittee on Health & Environment of the House Committee on Energy and Commerce, on Quality Assurance in the Clinton Health Plan, January 31, 1994.

³⁴ See Ken Wing, "Title VI and Health Facilities: Forms without Substance," 30 Hastings L.J. 137 (1978). During the Reagan-Bush years, such enforcement was abandoned altogether. See Investigation of the Office for Civil Rights in the Department of Health and Human Services, Committee on Government Operations, April 15, 1987. As a result, data that might reveal the full extent and contours of health care discrimination, data that is essential to civil rights enforcement, is missing. See David Barton Smith, "The Racial Integration of Health Facilities, 18 J. of Health Politics, Policy and Law 851 (1993).

³⁵ See, e.g., Council on Ethical and Judicial Affairs, AMA, "Black-White Disparities in Health Care," 263 JAMA 2345 (1990); Kenneth C. Goldberg et al., "Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for All 1986 Medicare Patients," 267 JAMA 1473 (1992).

(aa) Data collection. Effective enforcement of civil rights is dependent, in large part, upon the existence of relevant data. Indeed, the Act provides for the broad collection of data regarding enrollment, utilization, outcome, health care provider certification, and consumer satisfaction. (Sec.5101). Significantly, however, the Act does not provide for collection and dissemination of data on enrollment, utilization and treatment of protected groups. The Act should be clarified to provide for the collection of self-reported data on the consumer's race/ethnicity, gender, potentially disabling conditions, age, national origin, language, and socioeconomic class. In addition, computerized data in all parts of the system -- the National Health Board, states, Alliances, health plans, and plan providers -- needs to be gathered in a uniform, compatible format. This data should be made available to the public in a manner and in a format that protects individual privacy while allowing for effective civil rights enforcement.

A uniform health care claim form is proposed. (Sec.5130) It is to be modeled after the recently promulgated UB-92 used for hospital billing. The UB-92 collects information on gender and age. Significantly, however, it does not record the race/ethnicity of the consumer. The UB-92 recently received OMB clearance and is being disseminated for use by the Department of Health and Human Services despite complaints from civil rights organizations that the form fails to collect race/ethnicity-based utilization data and, as a result, fails to allow enforcement of Title VI of the

Civil Rights Act which prohibits health care providers that receive federal financial assistance from discriminating on the basis of race, color, or national origin. This data, and amendment of the UB-92 claim form and successor forms, is essential to monitor adequately the treatment and health status of people of color.

(bb) Uniform prohibition on discrimination throughout the system. Although the Act contains many varying antidiscrimination provisions, it does not broadly prohibit discrimination by all components of the system. For example, the Act is silent with respect to discrimination by the National Health Board, states are prohibited only from discriminating in establishing alliance boundaries (sec.1202(b)(4)), and regional (but not corporate) alliances are prohibited from discriminating against health plans on the basis of race, gender, ethnicity, religion, mix of health professionals, location of plan's headquarters, or (subject to exceptions) organizational arrangement. (sec.1328(a)). Health plans offered by both regional and corporate alliances appear to be covered by the same antidiscrimination provisions (sec.1402). No mention is made of discrimination by individual providers.

The Act should contain a broad, general anti-discrimination provision prohibiting federal agencies, states, regional and corporate alliances, health plans (including employer-funded or self-insured plans) and individual providers from engaging in practices that have the effect of discriminating on the basis of race, color, national origin, language, sex, sexual orientation, age, socioeconomic class, religion, disability, perceived health

status, or anticipated need for services. Practices such as reducing coverage for a single diagnosis (such as AIDS) should be clearly prohibited for all types of alliances and health plans.³⁶

(cc) Uniform designation of protected groups. The listing of groups protected against discrimination ought to be consistent throughout the Act. It is not. The Act contains five different prohibitions on discrimination: one applies to states, another to Alliances, and three different provisions apply to health plans. Each of these sections lists a slightly different set of protected groups. The characteristic of sexual orientation, a source of widespread discrimination in connection with the HIV epidemic and in other contexts,³⁷ is not mentioned as a protected group.

The groups contained in § 1402(a) prohibiting health plans from discriminating in enrolling consumers is different from the groups set forth in § 1402(c) generally prohibiting health plans from engaging in discriminatory practices. The specific anti-discrimination provision that applies to alliances extends only to race, color, national origin, disability, and age, a more limited

³⁶ See McGann v. H. & H. Music, 946 F.2d 401 (5th Cir. 1991), cert. den. sub nom. Greenberg v. H. & H. Music, 113 S.Ct. 482 (1992) (self-insured employer's reduction of lifetime maximum medical benefits from \$1 million to \$5,000 for AIDS-related claims only, after employee had filed AIDS-related claim, upheld as legal under ERISA).

³⁷ See, e.g., Testimony of the Human Rights Campaign Fund, National Center for Lesbian Rights, National Gay and Lesbian Task Force, and the American Association of Physicians for Human Rights before the Subcommittee on Health and the Environment of the House Energy and Commerce Committee, January 31, 1994, at 3-4 (documenting widespread discrimination on the basis of sexual orientation against lesbian and gay patients and health care providers).

listing of protected groups than those protected against discrimination by health plans.

The Act should contain a broad, general anti-discrimination provision prohibiting practices that have the effect of discriminating on the basis of race, color, national origin, language, sex, sexual orientation, age, socioeconomic class, religion, disability, perceived health status, or anticipated need for services.

(dd) Use of an "effects" test. The Act explicitly incorporates an effects test to measure discrimination by health plans. However, it does not expressly apply an "effects test" to the activities of the National Health Board, the states, or Alliances. By including an effects test only for health plans, the Act opens the door to the argument that only intentional discrimination is prohibited elsewhere.

The Act's other prohibitions on discrimination need to include an effects test. In addition, adding a broad, general anti-discrimination provision prohibiting all components of the system from engaging in practices that have the effect of discriminating would clarify this issue.

(ee) Standards governing an "effects" test. The Act needs to state clear evidentiary standards to be used in evaluating complaints of discriminatory effects. This standard should provide that a policy or practice that has the effect of discriminating is prohibited unless the entity can demonstrate that the policy or practice is necessary to the provision of health care and cannot be

substantially accomplished through less discriminatory means. All components of the system should also be required to make reasonable modification in policies and procedures when necessary to provide health care services to protected groups.

At present the Act provides that health plans do not violate the ban against practices that have the effect of discriminating if the policy or practice "is required by business necessity." Sec. 1402(c)(3). Aside from not making clear that the defendant should have the burden of proving business necessity, the use of the term "business necessity" is troubling because that term is used in both Title VII and the Americans with Disability Act to test employment criteria that have a disparate impact. The purpose of the Health Security Act is to guarantee access to health services. Use of employment law terminology will almost certainly confuse courts about the goals and purposes of the act's anti-discrimination provisions and the appropriate standards to determine what explanations can justify a health care policy with a disproportionate adverse effect.

Because providing health care is the goal of health care reform, the standard to justify a policy with a disproportionate impact should reflect the fact that it is "necessary to the provision of health care and cannot be accomplished through less discriminatory means." This phrase is modeled on the one used in Title III of the Americans with Disabilities Act which prohibits places of public accommodation from using practices that have the effect of discriminating on the basis of disability unless the

criteria can be "shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered." ADA § 12182(b)(2)(A)(i).³⁸

The standard must do more than test whether the challenged policy is necessary to the provision of health care; it must also ensure that the goal cannot be substantially accomplished through less discriminatory means. Evidence of less discriminatory alternatives provides the framework for evaluating the need for a practice that disparately impacts on a protected group. The existence of workable alternatives demonstrates that the challenged policy is insufficiently related to the asserted goal or that the interests advanced by a particular policy are not important enough to justify use of the policy in light of its disparate impact.

A requirement that states, regional and corporate alliances, plans and providers make reasonable modification of policies and procedures when necessary to provide health services to protected groups seeks to ensure equal access to health care by placing an affirmative duty on all components of the system to consider the needs of minority and other protected consumers, and to deliver services in a manner that meets these needs. The requirement of "reasonable" modification recognizes that meeting the needs of these consumers may sometimes require more costly administrative policies. Thus, a modification may be "reasonable" and still be

³⁸ The ADA also requires reasonable modifications in policies and practices to accommodate individuals with disabilities unless the entity can demonstrate that making such modifications would fundamentally alter the nature of the services. ADA 12182(b)(2)(A)(ii).

more expensive as long as it does not place an undue financial and administrative burden or require fundamental alteration in the nature of the program.³⁹

The Act provides that complaints against health plans alleging a violation of section 1402(c)(3) on the basis of age or disability will use the "standards applied under" the Age Discrimination Act and the Americans with Disabilities Act. Sec.5238. The standard just proposed for other violations of the Act complements the evidentiary standards in the Age Discrimination Act and the Americans with Disabilities Act, and thus would provide a coherent, consistent approach to antidiscrimination standards throughout the Health Security Act.

(ff) Private rights of action. Section 5238(A)(1) provides for private rights of action to enforce claims of discrimination by health plans arising under section 1402(c). The Act should be amended to also create private rights of action against health plans that discriminate in enrollment practices in violation of section 1402(a).

In addition, sec. 5238(a)(3) does not explicitly allow courts to award equitable and injunctive relief in a private action by aggrieved persons, and should be amended to so provide, as does sec.5238(c), governing enforcement actions by the Attorney General.

(gg) Alliances as federal fund recipients. The Rehabilitation

³⁹ See, e.g., ADA sec. 12182(b)(2)(A)(ii), requiring places of public accommodation to make reasonable modifications to accommodate people with disabilities unless the entity can demonstrate that the modification would fundamentally alter the nature of the services.

Act, the Age Discrimination Act and Title VI of the Civil Rights Act (which applies to race, national origin, and ethnic discrimination) prohibit "programs and activities" that receive federal funds from discriminating. According to the Act, Alliances are treated as federal fund recipients for purposes of these civil rights statutes. However, to achieve its maximum effect, the Act should be clear that "programs and activities" include the actions of health plans and individual providers that receive federal funds through the Alliance. Broad anti-discrimination protections within the Act itself are still crucial because the existing civil rights laws do not preclude discrimination based on sex, religion, language, socioeconomic class, perceived health status or anticipated need for health services.

(hh) Health Status and Access Goals. Finally, the bill needs to create a process by which states establish periodic goals for reducing racial, economic and other disparities in health status and health access. One way to accomplish this is to require states to submit a periodic plan for improving health outcomes and reducing health status disparities. A civil rights pre-clearance of these documents prior to receipt of federal funds would create an important incentive to assure that a reorganized delivery system actually results in improved health status for the most disadvantaged of Americans. Federal pre-clearance should be part of the submission of state plans to the National Health Board, with time frames sufficiently long to permit meaningful federal review and negotiation with the states. Moreover, states failing to meet

their pre-clearance promises should be required to remedy the problem.

(ii) Exclusion of Undocumented Aliens. The Health Security Act, while promising universal coverage, in fact excludes millions of persons living in the United States as undocumented aliens. See secs. 1001(c)(2), (3), 1005(a), 1902(1), 1902(36). Four groups of such persons have particularly strong cases for eligibility. First, pregnant women who are otherwise eligible for Medicaid and who are residing in the United States without approval from the Immigration and Naturalization Service (INS) are currently eligible for Medicaid prenatal care. See Lewis v. Grinker, 965 F.2d 1206 (2nd Cir. 1992) Such care is of obvious human, public health, and cost-saving value to the children themselves (who are American citizens when born in the United States) and to the society at large. The Health Security Act should not reduce the extent of coverage already available.

Second, there are strong arguments that all children, including children with the status of undocumented aliens, should be eligible under the Health Security Act. Children do not choose their legal status, and are especially at risk for illness that impedes development and functioning, as Congress has recognized in the EPSDT and other children-oriented Medicaid programs. Many of these children will eventually legalize their status, and in any event, denying them care "will have long-term costs for American

society as well as the children themselves."⁴⁰

Third, some aliens have employment authorization from the INS, but do not fall into the categories granted eligibility by the Act. These persons are legal employees for whom employers appear to be required to pay health care premiums. (See secs. 6121, 6122(b)(3)). Nevertheless, they and their families (some of whom may be American citizens) are not eligible for coverage under the Act (secs. 1001(c)(2), (3), 1005(a), 1902(1)). This is unfair (because premiums are being paid), unwise (because of health risks to the individuals and to the community), and inconsistent with the goal of universal coverage.

Fourth, the Act does not provide coverage for the citizen and legal immigrant members of undocumented household heads. This is discriminatory, and undermines public health and cost savings goals in the areas of child health, pre-natal care and contagious disease control.

(3) Organized Consumer Advocacy

In addition to individual claims and private rights of action, a third approach, organized consumer advocacy, is essential.

The experience of low- and middle-income consumers enrolled in HMOs in Wisconsin, Michigan, Pennsylvania, California, and other states suggests that many important issues are actually addressed

⁴⁰ Jane Perkins and Abigail English, "Evaluating Health Reform Proposals in the Interest of Children and Adolescents," Clearinghouse Rev., Aug./Sept. 1993 at 428, 430.

through structures other than individual grievances.⁴¹ State employees may have union representation on health plan purchasing boards. Low-income patients or their advocates may serve on formal or informal advisory groups. In Wisconsin, for example, a coalition of advocates, including a minority health coalition, nurses and other health care workers, housing and children's health activists and legal services and public interest lawyers, meet regularly with HMO management and state regulators to provide input into the contracting process between the HMOs and the state. From this organized and persistent effort, there have been significant changes in the Wisconsin's Request for Proposals (RFPs) that have addressed such issues as increased reimbursement for primary care providers in underserved areas, HMO capacity to communicate in the language of enrollees, improved mental health and drug abuse treatment, and HMO training for providers to improve communication with enrollees.⁴²

While in theory these issues might have been raised through individual grievances or "claims," it seems evident that a great many important issues may not be raised, or may not receive adequate attention, in a process based solely on the initiative of individual patients. Organized consumer input is thus very important both at the level of the health plans, and at the

⁴¹ See, e.g., Louise Trubek, "Making Managed Competition A Social Arena: Strategies for Advocates," Brooklyn L. Rev. (forthcoming, 1994); Rosenblatt (1985-86), supra note 15, at 962-965.

⁴² See Trubek, supra note 41.

Regional Health Alliance and state government levels, where important decisions are made about contracts with and reimbursement to plans, quality of care, consumer information, and additional services to overcome access barriers due to geography, income, race, and language.

As currently written, the Health Security Act does not acknowledge the role of organized consumer advocacy or explicitly support its functioning. Three kinds of support are important.

(a) Availability of Information. In order to articulate and pursue consumer interests, advocates and consumers must have access to a broad range of relevant information. Although the information that the Alliances must make available to consumers under section 1325 is useful for enabling consumers to make comparisons among plans, it is considerably less than that currently made available to organized advocates in some areas. The Act should be amended to create a presumption that all health care information collected pursuant to section 5101 by the National Health Board, the states, and the alliances, and other information collected by other government agencies, should be available to the public, subject to protections for patient privacy (discussed below) or publicly articulated justifications for nondisclosure permitted by National Health Board regulation.⁴³

(b) Access to the Decisionmaking Process. Organized consumer

⁴³ See also Testimony by Geraldine Dallek, Executive Director of the Center for Health Care Rights, 520 S. Lafayette Park Place, Suite 214, Los Angeles, CA 90057, before the Subcommittee on Health & Environment of the House Committee on Energy and Commerce, on Quality Assurance in the Clinton Health Plan, February 3, 1994.

advocates (and others) should not have less access than they do now to the decisionmaking process, and indeed should have more. At a minimum, the Act should be amended to require regional and corporate alliances to create consumer advisory boards as well as the currently required (for regional alliances) provider advisory boards (sec.1303), and to insure disclosure of information about, and the opportunity for public input into, the contracting process between the alliances and the plans.

(c) Funding. The Act currently contains funding for advocacy on behalf of individuals in its provisions for attorneys fees (sections 5204, 5205, 5237-38, 5240), and SALT strongly supports these provisions. In the light of the importance of organized consumer advocacy, two additional forms of funding should be added to the Act. First, consumer membership on the governing board or (if enacted) advisory board of an alliance is likely to involve a major commitment of time and energy. Representatives of employers, particularly large employers, are likely to have extensive financial and staff support from their companies. Funds should be made available to pay the out-of-pocket expenses and reasonable time reimbursement for consumer and small-business governing board members, and to provide designated staff support for those members. Second, funds should be made available at the regional alliance level to pay for at least some of the costs of organized consumer advocacy, following the precedent of Medicaid managed care

programs⁴⁴ and of protection and advocacy agencies under the Developmental Disabilities Act.

(4) Privacy of Personal Information

A complex health care information infrastructure will exist under a reformed health care system as proposed in the Health Security Act. The success of the new system will depend, in part, on the accuracy of the information and the privacy rights of individuals to control the disclosure of personal information. Americans believe that their privacy rights are not adequately protected. In a 1993 Harris poll on health information privacy, 80% of the respondents indicated their concern about threats to privacy. Eight out of ten respondents believed that consumers had lost all control over how personal information about them is circulated and used.⁴⁵

(a) Problems with use of the Social Security Number (SSN)

Health security cards would be issued to all citizens and lawful residents. Eligible individuals should have a unique identifier to enable the new health care system to operate more efficiently. Perhaps the most critical decision regarding privacy is whether to use the social security number (SSN) as the individual identifier. The SSN is not a completely reliable

⁴⁴ See Rosenblatt (1985-86), supra note 15, at 964 (reporting on contract between state Medicaid agency and advocacy group to monitor and improve consumer experience with managed care).

⁴⁵ Louis Harris and Associates, Westin A.F. Health Information Privacy Survey. Atlanta: Equifax, 1993.

identifier: it is not unique, there are multiple users of a single number, and it is difficult to determine whether a random nine-digit number is a valid SSN. The SSN is used extensively for a large variety of non-health related purposes. Among the users of the SSN are debt collectors, department stores, utilities, check validation services, supermarkets, cable television, credit card issuers, banks, major oil companies, the Internal Revenue Service, other Federal agencies (military, Parent Locator Service, Food Stamps, Selective Service System), mailing list companies, credit bureaus, law enforcement agencies, insurance companies, the Medical Information Bureau, motor vehicles departments, employers, schools and universities, and state agencies. The SSN provides a capacity to link databases on many aspects of a person's life.

(b) Needed Actions

The constitutionality of the new health care system and the confidence of consumers can be achieved only by establishing a national privacy policy. The actions needed to establish a coherent national framework include the following:

(1) Establish, through preemptive federal legislation, national privacy safeguards based upon Fair Information Practices. In order to ensure that the privacy of health care data is taken seriously, it will be necessary to establish effective mechanisms for enforcement. This includes a private right of action by aggrieved parties and significant penalties for persons or institutions that breach legal requirements. A national privacy framework should be founded on a code of fair information

practices. The code would stipulate, inter alia, that individuals about whom data are collected have the right to know about and to approve the uses to which the data are put, that no secret data systems are permitted to exist, that individuals have the right to review and to correct data about themselves, and that data may be collected and used only for legitimate purposes.

(2) Establish a universal identifier that is secret and secure; do not use the SSN for this purpose.

(3) Issue effective security standards and guidance for health care information.

(4) Establish a Data Protection and Security Panel(s) as part of the National Health Board for overseeing privacy and security.

(5) Establish a comprehensive program fostering privacy and security education and awareness.

The success of a new health care system depends in large part on the integrity of information and the confidence of the public that private information will be vigorously protected.

(5) Medical Malpractice Reform

The medical malpractice reforms in Title V, Section D, create additional barriers to patient claims, while providing little in the way of more efficient resolution.

The Act's reforms do not take into account recent empirical research on medical malpractice. Patients suffer injury at the hands of providers with surprising frequency, but usually do not sue. The Harvard Medical Practice Study, the largest and most

comprehensive study to date of medical injuries in the hospital setting and the role of the malpractice system in compensating those injuries, found that patients injured by provider error are not adequately compensated.⁴⁶ The Harvard Team surveyed a representative sample of 31,000 patients hospitalized in New York state in 1984 to determine the levels of iatrogenic injury and to separate injuries traceable to a provider's negligence from pure "accidents." The Study found that the incidence of adverse events suffered by hospitalized patients was 3.7%, with 28% of these due to negligence. About 1% of all hospitalized patients suffered a negligent medical injury. (p. 43) If this finding is extrapolated to the United States as a whole, 150,000 iatrogenic deaths occur every year, with more than half due to negligence (pp. 55-56).

Poor, elderly, or minority patients suffered higher negligence rates, with age and insurance strong determinants of negligent injury (p. 56). Hospitals varied in negligence from 1% to 60% (p.47), with teaching hospitals having lower rates of negligence (p. 49-50). Those hospitals with significant numbers of minority patients had higher levels of negligence than other hospitals.

The Harvard Team concluded that the real problem with the current malpractice system is "...not a litigation surplus, but a litigation deficit." (p.140) Patients file too few claims. The chances that a claim will be filed by a patient with an identifiable negligent injury is only one in fifty (p.73). The

⁴⁶ For a summary of the findings, see Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (Harvard University Press 1993).

poor, minorities and the old suffer higher levels of harm, and sue less often.⁴⁷

Against this background, the Act's proposed reforms are markedly one-sided. The Act preempts state law unless state law "provides for defenses or places limitations on a person's liability" in addition to those in the act (sec. 5301,(a)(2)). This is strictly a one-way street in which the only state discretion allowed is for restricting consumer rights to sue. The provision requiring patients to obtain a "certificate of merit" from a qualified medical specialist (sec. 5303) imposes substantial up-front costs on patients that may deter filing or settlement of meritorious smaller claims. Moreover, sanctions may be imposed only on patients or their attorneys for required statements "submitted without reasonable cause and . . . found to be untrue." (Sec.5303(d)). No comparable penalties are imposed on defendants or their attorneys whose defenses fail to achieve a threshold standard of plausibility.

In addition, the required alternative dispute resolution methods (sec.5302(b)) are not likely to be effective. The literature on alternative dispute resolution has consistently found that the benefits of ADR are often outweighed by costs in delay.

⁴⁷ Compare Burstin et al., "Do the Poor Sue More?", 270 JAMA 1697 (1993) (finding that poor patients and uninsured patients were significantly less likely to file malpractice claims, after controlling for severity of medical injury, and finding no significant differences in filing rates by race, gender, payer status, or age.)

ADR provides another layer of discovery, but little more.⁴⁸

The malpractice reform proposals in the Health Security Act are a step in the wrong direction. Reforms must instead find ways to identify medical error, promote compensation to injured patients, and simultaneously improve the quality of care delivered. The enterprise liability demonstration project (sec. 5311) in the Act may offer such potential. Such a form of liability, channeling liability to health care institutions, may better promote quality, and provide compensation to more injured patients.

⁴⁸ A study by the Florida Medical Association in 1985 found that panel effectiveness was unproven, and that other court efforts such as a special malpractice court, or other procedural reforms, might be more effective. Studies by several states of the performance of their panels have also not been encouraging. New Jersey and New York both recommended that a mandatory screening approach be dropped in favor of some form of voluntary system, such as optional mediation. Arizona studies have found severe problems with the Arizona panels. See Florida Medical Association, *Medical Malpractice Policy Guidebook* (1985); *Perna v. Pirozzi*, 92 N.J. 446, 457-59, 457 A.2d 431, 437 (1983) (presenting committee findings on New Jersey's panel system); Jona Goldschmidt, "Where Have all the Panels Gone?" 23 *Ariz.St.L.J.* 1013 (1992).

(6) Conclusion

This testimony represents the SALT Committee's initial effort to deal with numerous and complex issues raised by the Health Security Act. Because of time constraints, the Committee was not able to review the entire final text of the testimony before its submission. However, many Committee members made valuable and generous contributions to the testimony, and all of the Committee members stand ready to work with Congress and the Administration on developing and resolving the important issues of national health reform.

Respectfully submitted,

Co-Chairs of the Committee:

Rand E. Rosenblatt
Rutgers University Law School
5th And Penn Streets
Camden, NJ 08102
TEL: (609) 225-6379
FAX: (609) 225-6516
Home: (215) 849-6080

Sylvia A. Law
New York University Law School
40 Washington Sq. So.
New York, N.Y. 10012
TEL: (212) 998-6265
FAX: (212) 995-3156

Mr. WAXMAN. Mr. Lindberg.

STATEMENT OF BRIAN W. LINDBERG

Mr. LINDBERG. Thank you.

Again, my name is Brian Lindberg, I am the executive director of the Consumer Coalition. I apologize for having to fill in today for our colleague from the National Consumers League.

I want to thank you for inviting us, Chairman Waxman, and congratulate you on your long-time efforts in behalf of improving our health care system. We appreciate that. The coalition also applauds the President's all-out effort to reform the health care system, and we feel it is our job now to make some recommendations to improve the legislation as it has been introduced.

Any health care system needs strong consumer protections and quality improvement mechanisms, but particularly a managed care model relies on competition between health care plans and providers to drive down the costs of care and supposedly the quality of care upward. There is obviously some incentives, though, in that kind of a system to have providers provide less service to the consumer.

I would like to ask that my written testimony and our two white papers on consumer information and due process be entered into the record.

Mr. WAXMAN. We will be pleased to receive that for the record.

Mr. LINDBERG. Thank you.

Let me start with consumer information. Under any new system, consumers need easy access to unbiased information to help them make meaningful choices between the plans, providers, and coverage options. I should mention here that consumers will benefit greatly by the inclusion of the point-of-service option. A managed care system's competitive success depends greatly on the quality of the information that is provided to consumers. We have some ideas about improvements that should be made in this area.

The consumer handbook should include the results of the consumer satisfaction survey, for example, and enrollment and disenrollment figures collected by the health care information system. Consumers will also need information, such as physician certification and repeated disciplinary actions, and they will need condition-specific information to be able to choose between doctors and hospitals when they face a major surgery or health care decision.

A lot has already been mentioned here on the ombudsman program. Let me just make a couple of quick points. We believe that it is a great idea to have some sort of a check-off where consumers can actually put part of their premium toward an ombudsman program, but it has to also have a steady source of funding. I look at that as only additional funding added on to whatever a set amount would be for the ombuds program.

We also believe strongly that the ombuds program must be available to individuals who are in corporate alliances, and that alliances themselves should not house the ombuds program. This we believe would be a conflict of interest because of the fact that consumers will have problems with both plans and alliances.

With regard to quality improvement and public accountability, we believe that there is an excellent foundation set forward in the

Clinton plan. We also believe that there is a missing component. We believe that what we would call "quality improvement foundations" should be created in each State by the National Quality Management Council through competitive grants.

These QIF's would be governed by a consumer majority board which would also include experts in a variety of health and quality research fields. Their job would be to monitor quality and help improve quality. They would be involved in development of and support of quality improvement activities at the plan level, provide guidelines, adherence monitoring and profiles of the database for low rates of utilization.

With regard to consumer representation, we believe public accountability depends greatly on consumer representation on boards, on the advisory boards, including the advisory boards of the regional and corporate alliances. Note that the corporate alliances currently don't have this kind of representation. We feel that if you look at all the boards throughout the plan, it would serve consumers greatly to increase their membership on all of them.

Licensing and certification. Rigorous professional licensing and accreditation and plan certification is needed to ensure quality. We believe this subcommittee should address ways to mandate sufficient financial support for licensing boards and mandate at the national level at least minimum functions to ensure consistency from State to State.

With regard to consumer due process protections, our coalition feels that there has been a very strong move by the administration in this area, and there are some corrections or improvements that could be made, but in general, they have done a good job.

In conclusion, I request also that the subcommittee consider the written testimony of the National Health Law Program which addresses a very important issue for consumers, that is the marketing practices of managed care.

Thank you for having us testify today.

[Testimony resumes on p. 472.]

[The prepared statement of Linda Golodner follows:]

STATEMENT OF LINDA GOLODNER

Mr. Chairman, members of the Committee, my name is Linda Golodner. I am the President of the National Consumers League, a private nonprofit organization that has represented consumers since 1899 on workplace and marketplace consumer issues. Health care quality has always been one of our highest priorities. Today, I am representing the Coalition for Consumer Protection and Quality in Health Care Reform, a coalition of more than 25 consumer groups.

We thank you for providing us with the opportunity to testify today. We congratulate you, Chairman Waxman, for your distinguished record of support for health care improvements for all Americans. The Coalition also would like to thank, for the record, your colleague Representative Ron Wyden, who has shown early and steady support for our efforts.

The Coalition applauds the President's all-out effort to reform the health care system. Specifically, we are pleased with the attention to consumer empowerment through an extensive system of data collection, analysis and dissemination. For the first time ever, consumers will base their plan selection on comparative information. We are delighted that the plan recognizes the importance of choice through requiring the offering of point-of-service options. Included in the plan is an ombudsman program, a vigorous appeals procedure and a separate grievance procedure, and a sound foundation for quality improvement and public accountability. The language in the bill sends the strong signal that consumer protection and quality are important to this Administration. Our job now is to flesh out the intent of specific consumer and quality provisions and to suggest specific improvements where necessary.

First, I would like to briefly outline our vision of consumer protection in the new health care system. This new system relies on competition between health care plans and providers to drive the cost of care down and the quality of care up. But there are obvious incentives for plans to contain costs by providing less service.

Under any new system consumers will need easy access to unbiased information to help them make meaningful choices between plans, providers, and coverage options. They will need an advocate or ombudsman to help them understand and navigate through the system and assist with resolving complaints. They will want a grievance procedure for patient complaints. They will need an appeals process to address the denial, reduction, or termination of benefits, and quality issues quickly and fairly.

The system will need independent quality improvement organizations and quality assurance and public accountability through improved licensing, certification, and accreditation systems, and consumer control of governance structures. There must be guaranteed funding for these programs.

These are the elements of a health care system that is sensitized to the basic fact that the system -- physicians, nurses, pharmacists, other health care professionals, hospitals, and health care plans -- is there to serve those who need care, the consumers.

Today, I would like to address four areas of particular interest to consumers:

1. Information that should be provided to consumers through the consumer report card and other means;
2. The financing, location, and additional details for the ombudsman program;
3. Due process issues - grievance and appeals provisions; and
4. Quality improvement and public accountability.

Consumer Information

The Administration plan calls for easily understood, useful, comparative, consumer information published annually. The National Health Board will decide the type of information, but it is to include at a minimum: first, cost of plan; second, characteristics and availability of health care professionals and institutions in the plan; third, any restrictions on access to providers and services; fourth, a summary of quality performance standards. Consumers will need basic educational information to use the new health care system. In addition, some clarification and expansion is needed in the area of consumer information.

Comparative information. Congress should consider adding to the consumer handbook the following items: 1) the results of the consumer satisfaction survey conducted by the National Quality Management Council; 2) enrollment and disenrollment figures collected by the Health Care Information System to inform consumers about plan size and percentage of enrollees leaving the plan; 3) the ratio of complaints to enrollees; 4) the cost or implications of using services outside the plan; 5) premium increase trends to let consumers know which plan has the slowest rate of increase; 6) benefits covered beyond the standard benefit package; 7) how long the plan has been in operation; 8) ratio of primary care practitioners to enrollees; 9) ratio of board certified physicians to non-board certified; 10) names of participating hospitals and other providers; 11) the financial health of the plan; 12) phone numbers for information specialists who can explain plan details and the ombudsman; 13) any limitations on prescription drugs or procedures for each plan; and 14) any financial incentives that health care providers have regarding the services they provide. I refer you to our White Paper, "Minimum Requirements for Consumer Information," which I would like to request permission to submit for the record, for additional suggestions.

Plan-Specific Information. Once a person has chosen a plan, he or she should have access to further details about the plan's health care professionals to help select a physician. This information should be provided by the plan itself or by the health

alliance. Fact sheets on each of the physicians in the plan, their training, years of practice, board certification, faculty responsibilities, and confirmed disciplinary actions such as repeated malpractice payments should be provided in this documentation. Fact sheets on individual hospitals, home health agencies, laboratories, pharmacies, and other contracted health providers with lists of services and other details should be available upon request.

Condition-Specific Information. Condition or treatment-specific information is important to the person who faces a major operation or health care decision and should be available upon request. This information includes both hospital and physician specific practice profiles and outcomes data on a particular procedure or condition. This is similar to what has been done for coronary artery bypass graft surgery in both Pennsylvania and New York. The information could be presented on either a nation-wide, region-wide, or state-wide basis and could be available from the National Quality Management Council or its state-located Quality Improvement Foundations - which I will discuss later. The data should be appropriately adjusted for severity to avoid skewing outcomes for surgeons and hospitals serving a more vulnerable population. For a particular condition, this data could include:

- * number of surgeries performed (by hospital and by surgeon);
- * death rates within a certain time period;
- * infection rates and readmissions for the same condition; and
- * patient satisfaction survey results.

We believe that this committee should add these details to the Health Security Act which currently leaves too much of the consumer information up to chance and may promote inconsistency across the nation.

Ombudsman

We are pleased that the Health Security Act calls for the creation of ombudsman offices. We believe it is important to have ombudsman programs to assist consumers with their questions and concerns about the quality of services and facilities and in obtaining information about grievance and appeals options. The ombudsman should serve as a consumer advocate and should help him or her negotiate the system when necessary and resolve complaints if possible. We believe, however, that the Health Security Act should provide much greater detail regarding how this program will be designed, how it can be used by consumers, and what kinds of consumer information about the program will be provided.

For example, a major function of the ombudsman would be to work with individuals in (a) securing necessary information and assistance (including obtaining representation -- information and referral -- in filing a claim under sec. 5201-5243 of the Health Security Act and (b) providing information and assistance in filing grievances within a plan. This type of detail should be added to the Act.

If we are to take the ombudsman program seriously -- and consumers have every intention of doing so -- it must have a stable source of financing, not one of voluntary contribution. We think it would make sense to determine the cost of this and other quality improvement and consumer protection systems within the Health Security Act and mandate that a percentage of premiums collected be set aside to cover their costs. The Health Security Act includes the option for alliance eligible individuals to designate one dollar of their premium towards an ombudsman program. This approach puts the program in jeopardy from the beginning. Our concern is that not every enrollee will be aware of the value of an ombudsman until they have a problem and need such services. For the ombudsman system to be effective, it needs a trained, full-time staff. Without an assured financial base, it will be unable to plan from year to year. Under the current framework it is unlikely to become a successful advocacy program for consumers. We recommend that this important program be assured dependable financing.

The Administration's legislation states that "each regional alliance must establish and maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and the alliance." To whom does the corporate alliance enrollee turn? These enrollees should have the same access to a consumer advocate or ombudsman.

Further, the Health Security Act locates the ombudsman offices in the alliances, which creates a clear conflict of interest. We agree that the ombudsman must assist with both plan and alliance-related problems, but it is unrealistic to expect the ombudsman to effectively deal with problems that arise within the alliance if it is located there and receives its funding from it. We understand that some hospitals, newspapers, and other organizations serving the public employ their own ombudsman. However, this is not the model consumers have in mind. Rather, we believe that the program should be modeled after the State Long-Term Care Ombudsman Program mandated by the Older Americans Act that serves consumers in nursing homes, and other programs which attempt to avoid such potential conflicts of interest. We have seen this model work quite successfully. It is the consensus of the Long-Term Care Ombudsmen that the program is most effective when it is housed independent of the organization(s) whose services it has a mandate to monitor.

The following is a list of issues that we believe should be specifically addressed regarding the ombudsman: its relationship to the State Long-Term Care Ombudsman Program; ensuring nationwide consistency; conflict of interest protections; eligibility requirements; procedures for access by ombudsman to facilities, patients, records, etc.;

a uniform system to collect and report data regarding complaints; confidentiality and disclosure procedures; and access to legal counsel for the ombudsman. We ask the Subcommittee to consult with the National Association of State Ombudsman Programs and the National Association of Protection and Advocacy Systems for addition input on this important issue.

Consumer Due Process Protections

The Coalition believes that consumer notice, appeal, and grievance rights -- collectively referred to as consumer "due process" rights -- are essential in any national health care plan. Under a managed care system, health plans and the utilization review systems work to keep the cost of care down. In some instances this will be done at the expense of the health of the enrollee who seeks services. Therefore, access to an independent and timely appeals process is critical to maintaining quality care for consumers.

Appeals Process. The Coalition is quite pleased with the review structures envisioned by the Health Security Act, "Subtitle C -- Remedies and Enforcement." Its basic approach is consistent with our White Paper, "Consumer Due Process Protections," which we request be inserted in the record. We would, however, like to raise several concerns that should be addressed as refinements to the Health Security Act.

First, we believe that Congress must clarify the circumstances for providing notice to patients when decisions to deny, reduce, or terminate a service or payment have occurred. We have concern for patients who may not know their benefits or options - these are often low-income or less educated consumers. This notice should state the specific reasons for the decision and describe the appeals process available to the patient. We would argue that notices should be triggered automatically when certain benefits, such as hospital, nursing home and home health care, have been denied, reduced, or terminated. Other circumstances triggering automatic notice should be defined in regulations.

It should be clarified that a "claim" under the Health Security Act, includes the review of a decision to terminate services. Proper notice to patients is particularly important in this situation. We have concern for patients who may not know that their benefits or options have been reduced or that certain options are not being made available to them. We suggest that you also consider using periodic notices to remind consumers of their rights.

Another issue that the Subcommittee may consider is whether under the Administration's proposal the burden of proving the necessity for a particular treatment or service is the consumer's. It appears to us that the burden falls too heavily on the consumer and could prove to be a great obstacle, particularly for low-income

beneficiaries. Similarly, the current bill places the responsibility and costs of purchasing second opinions on the beneficiary. This places an unacceptable burden of proof on the beneficiary. For low-income individuals in particular, this burden will negate the appeal right.

Grievance Process. Each alliance should assure that its plans initiate and maintain a grievance process for patient complaints about problems other than denial, reduction, or termination of service or payment. We believe the grievance process should have the following components:

- (a) initial investigation of oral and written complaints from patients shall be performed by a patient advocate, who will prepare a written report for the plan and the consumer within 15 days;
- (b) action in response to the patient advocate's report shall be recommended by a grievance committee within the insurer or health plan within 30 days; copies of the complaint and recommended response shall be available to members of the insured group or health plan and appropriate regulatory agencies; and
- (c) beneficiaries who are dissatisfied with the grievance committee action shall be able to lodge further review with the Complaint Review Office, which is created by the Health Security Act.

We would also like the Subcommittee to consider the role played by the Early Resolution Program or alternative dispute resolution mechanisms. We mention this because it is our belief that although these mechanisms should be available to consumers and can be helpful in some instances in resolving grievances and complaints, not all grievances and complaints are suitable for the alternative dispute resolution process.

Other issues that we believe are important for you to consider are: 1) shortening to 15 days the time-period for plans to make decisions on claims; 2) removing jurisdictional amounts as a barrier to litigation about coverage policy and Constitutional issues, particularly for low-income beneficiaries; 3) requiring uniform appeals rights under all plans and alliances; 4) further details on what this system will address (e.g. refusal by gatekeeper to refer to a specialist, out-of-plan emergency disputes); and 4) whether consumers will have access to utilization review criteria information.

We will submit any further recommendations on due process issues to the Subcommittee in writing.

Quality Improvement and Public Accountability

The Consumer Coalition believes that consumer information, consumer protection, and quality improvement programs must be accountable to the public, independent of providers and payers of health care, and free of potential conflicts of interest.

Health Security Act Quality Provisions. As I mentioned, we believe with great conviction that quality oversight must be independent and external of providers. The Health Security Act provides an excellent foundation for independent monitoring of quality in the following ways. First, the National Health Board would establish a National Quality Management Program (NQMP) designed to oversee a performance based quality management and improvement program.

Second, the National Quality Management Council would manage the NQMP and develop a set of national measures of quality performance. These will be used to assess health care services in relation to access, appropriateness, effectiveness, outcomes, health promotion, prevention, and consumer satisfaction.

Third, the Council will conduct periodic surveys of health care consumers based on a standard design and administered to all plans. This information will be of great importance to other consumers and should be used by plans for quality improvement.

Fourth, the performance reports that each alliance will publish and that the Council will provide to Congress, and the practice guidelines and utilization protocols will serve consumers and providers with information to improve quality and provide consistency throughout the system.

Quality Improvement Foundations. The aforementioned approach in tandem with the data collection system provides a foundation for quality improvement. However, the Coalition strongly believes that there is a missing component in the Health Security Act's quality improvement system. The elimination of the technical assistance foundations from the September 7th draft of the Administration's plan exacerbates this problem. We had considered the technical assistance foundations as a possible location for the independent, external entity to monitor and improve the quality of care. The bill currently does not satisfy our basic principle that there must be an external quality review entity, independent of the payer-based (alliance) and provider-based (plan) systems to monitor and improve quality in each state.

For lack of a better name, we will call these entities "Quality Improvement Foundations." They are needed to ensure that the consumer information, due process, advocacy, and other quality related aspects of our new health care system function properly. This entity must be free from potential conflicts of interest. It must have as a primary goal the protection of consumers from providers who would create barriers to quality care.

Let me take this opportunity to describe how Quality Improvement Foundations (QIFs) would fit into the new system.

The National Quality Management Council would provide competitive grants to create one QIF in each state. Funding would come from the National Health Board through an amount designated from each premium. The QIF would be governed by a consumer majority board, which includes others who are experts in a variety of health and quality research fields.

A QIF must be independent of purchasers and providers of care. Each QIF would perform the following quality monitoring and improvement functions:

- * Data analysis and data quality testing;
- * Dissemination of information on successful quality improvement programs;
- * Technical assistance to plans and alliances;
- * Development of and support for quality improvement activities;
- * Consumer information beyond the report card;
- * Practice guidelines adherence monitoring/feedback;
- * Profiles of database for low rates of utilization (immunization, infection rates, voluntary surgery); and
- * Quality assurance:
 - by providing information to consumers
 - feedback to licensing, certification, and accrediting entities and the National Quality Management Council.

We believe that all health care plans should be required to participate in the quality improvement activities of the QIF. This will ensure that quality improvement activities which are currently very successful in some hospitals and with some health care professionals will be used consistently across the nation. The QIF also will ensure that information regarding consistently poor care and plans that do not implement successful quality improvement programs will be forwarded to the appropriate licensing, and other regulatory entities, so that they can take appropriate action.

The Coalition believes that the QIF has an integral role to play in ensuring the quality of care for consumers. Given the current structure of the Administration's quality program, this independent entity would be in an ideal position to assist health care plans to learn from nationally collected and analyzed data. Outcomes data could be used by plans for quality improvement and by the QIFs for examining plans compliance with national practice guidelines and health services utilization protocols. As I mentioned, when plans do not meet standards or deviate from best practices, this information will be provided to the appropriate entities. This will lead to improvements in the quality of care for consumers and sanctions for those plans or providers that do not improve quality appropriately.

Along these same lines, the quality of care under the Medicare program must not be reduced as a result of a merger with the new system and its yet to be tested quality programs. In fact, until the new system can demonstrate equal or better quality improvement and consumer protection systems, it does not make sense to merge the two. The Coalition opposes the Health Security Act provisions which terminate the Medicare Peer Review Organizations.

Consumer Representation. One of the most effective ways to ensure public accountability is to mandate consumer representation on advisory boards, including the advisory boards for regional and corporate alliances, the National Quality Management Council, and state-located Quality Improvement Foundations. In fact, Coalition members would argue that consumers must have a majority on these advisory boards since they are both the recipients of care and the ultimate source of financing. The Administration's legislation does not yet provide adequate representation for consumers on these and other boards. Consumers are in a unique position to advocate for a system that delivers high quality care -- unlike payers or providers of care, they are immediately affected by any changes in the quality of care delivered and are free from potential conflicts of interest.

The Coalition is pleased that the Health Security Act recognizes the importance of consumer involvement by providing for consumer representation on some of the boards and advisory councils specified in the bill. However, we believe that the consumer role in the governance of the health care system must be strengthened. Consumers should have control of the boards of the regional alliances. With respect to the corporate alliances, we did not find any provision for consumer representation. We recommend that corporate alliances and Quality Improvement Foundations be governed by a board or council that is controlled by consumers, as well. We are also concerned that there is currently no provision for consumer representation on the National Quality Management Council or on the National Long-Term Care Insurance Advisory Council among others. We envision significant consumer representation on these and other councils and boards. Consumers have the greatest stake in assuring and improving quality in the new health care system and must be adequately represented.

In addition, for consumers to have a real impact on these various boards, funds must be made available for training and technical assistance. Adequate staff and resources must also be provided to enable consumers to effectively fulfill their roles. The Coalition believes that the health care legislation should specify that consumers should be generally representative of the ethnic, geographic, and socio-economic demographics of the people served.

Licensing and Certification. One area of quality assurance for which the Coalition has not yet completed its analysis, is improving the effectiveness of licensing, certification, and accreditation entities. They will play critical roles both in

establishing that providers and plans will provide quality care and in sanctioning those that fail to provide acceptable care.

For example, we believe that the Subcommittee should address ways to mandate sufficient financial support for licensing boards to enable them to effectively carry out their functions. It would also make sense for at least minimum functions to be determined at the national level to ensure consistency from state to state. Of course, consumers should also be represented on the boards of these entities. Furthermore, we suggest that you consider incentives and penalties to make licensing boards fulfill their missions and improve public protection.

Mr. Chairman, We believe that those who would like to protect the status quo in our health care system will distort the facts and attempt to scare consumers into believing that quality will suffer under the Health Security Act. We believe the improvements that we are recommending will protect quality further and provide consumers with the information, advocacy, due process rights, quality improvement, and public accountability that will make this reform better for American consumers of health care.

Chairman Waxman, the Coalition is grateful to you for holding this hearing and focusing your attention and the work of this Subcommittee on these critical issues. We look forward to working with you during the year as these issues are resolved.

Mr. WAXMAN. Thank you for your testimony.

Last week, we had testimony from the National Right to Life Committee, and they said they were against the President's plan on the ground that it will, I quote: "Perpetuate a two-tier system. Only the very wealthy who have enough resources to pay for even the most expensive health care on their own will be able to get adequate care, and the second tier subject to rationing will be not only the poor but also those in the middle class. This is because Americans will be forbidden to use our own money for supplemental insurance to protect our families from rationing", end quote. That was their statement.

They also, of course, are against the bill because of the abortion issue.

I would like to ask this panel, whose credentials as consumer advocates no one could challenge, whether there is any reasonable basis for the claim that the bill would lead to rationing of care to the poor and the middle class alike, sparing only the rich.

Mr. Lindberg?

Mr. LINDBERG. Well, I think that there is a possibility without the necessary protections for rationing to occur under most systems, but I would say that our current health care system is one of the most cruel in terms of rationing health care. We provide only the, shall we say, the last resort kind of care to many low income individuals.

There is very little activity in the preventive care area, and so I would argue that the Clinton plan does provide access to all Americans. I think that there are a couple concerns. We would want to make sure that consumers who were denied care under the current system would have the right to appeal and have the second opinion cover—

Mr. WAXMAN. You don't see rationing for certain segments of our population based on economic class?

Mr. LINDBERG. I don't see that that—that this plan promotes that, and certainly eliminates the kind of unfair treatment that low income and nonworking individuals who don't have health care right now have in our current system.

Mr. WAXMAN. I would like to hear from Professor Rosenblatt and Professor Law what you think about that charge.

Ms. LAW. Well, I think that rationing is pervasive today and it is not simply in relationship to low income people. I get calls all the time from people who have private insurance that denies them payment for service that they think are essential, and for years I have had to say to them there is really nothing you can do unless you can put money out of pocket to pay a lawyer because a lawyer won't take this kind of case on contingency, and some people have money and pay it and sue and win.

Now, I have to say, there is really nothing you can do unless you can pay a lawyer and unless you are insured other than through employment because the risk preempts even if you are willing to plunk down money and pay a lawyer.

So the arbitrary actions of private insurance today is pervasive, and I think it is one of the things that scares the American people about a new plan, because they know the old plan and they know that there is a lot of room for arbitrary treatment and it all just

underscores—we won't have a dual-track system unless we have effective remedies to make sure that dual track is not built into the system in the creation of the alliances, built in the practices of the people, and also unless we make sure that people have access to advocates along the lines that Professor Rosenblatt was suggesting.

Mr. WAXMAN. Before we get to that resolution process where we are going to have the determination about these disputes as to whether care was appropriately withheld, we want to see if there are ways to prevent these unjustified denials of care from occurring in the first place.

Clearly one item we need to watch very carefully is the matter of physician incentives that health plans are allowed to use. I believe the financial incentives affect physician behavior. If plans in effect pay physicians not to deliver care, many participating physicians won't.

We have had enough experience with this in Medicare and Medicaid, private insurance, and we have enacted specific prohibitions against plans placing physicians at substantial financial risk for hospital or other services without adequate protections.

Unfortunately, there is no comparable provision in the President's bill. My question is, would a system of administrative and judicial review of care denials, even one designed to your specifications, be sufficient to protect consumers from systematic underservicing or do you think we also need tighter Federal standards for plans to reduce the incentives to under serve before they are even allowed to market to people in an alliance?

Mr. ROSENBLATT. Yes, I agree very strongly that a system of appeals, no matter how well designed, is not going to capture all these problems, that some preventive standards of the sort you are talking about are very, very important and should be in the act.

I also think this ties into the notion of organized advocacy that we also talk about in the written testimony. There is a very important need to have input at the plan and alliance level to fine tune whatever standards are there and deal with new types of incentive programs that come along that may escape the regulatory process, and then there is a very important need for that ultimate judicial review backup if all these things fail, but I think you need all three things.

Mr. WAXMAN. Do you need a regulatory system to make sure that we can deal with some of these ways the plans are going to come up with that we don't even foresee at the moment that underserve?

Mr. ROSENBLATT. I would say so. You are familiar with the long history of HMO's in Medicare and Medicaid and there are strong market incentives toward under service. The regulatory system at least provides some backstop for the most egregious kinds of things, and with the other systems, maybe can make this thing work the way it is supposed to.

Mr. WAXMAN. I didn't get much of a sense of a regulatory system from Dr. Lee when he discussed the bill today. He seemed to rely heavily on report cards that would be prepared by the alliances or the plans themselves.

Some review by public health agencies which by and large really don't know about medical services as such, although they certainly

have some knowledge about it, and in the hope the States might enact something along these lines.

Do you see more in this bill than— am I missing something?

Ms. LAW. I was surprised at the administration testimony because I know that both Dr. Lee and Nan Hunter are familiar with our history of the last 30 years and it teaches us that the State agencies are not likely—do not have the capacity to do this, that the private accreditation agencies do not have a good track record, and that we need a stronger regulatory mechanism to make sure that the plans meet minimal standards, including minimal standards of financial arrangements and incentives.

Also, that information could be and is not now included in the consumer report card. I mean, consumers should know if their doctor is going to make money by denying them services. That is relevant information that is not part of the administration's proposal.

But whatever regulatory structure we have, I think our history suggests that it will only work if there is some opportunity for people who care about making it work to go to court and try to insist that their rights be enforced.

Mr. ROSENBLATT. I would just like to add to your sense of the importance of this information being available for public scrutiny, the financial incentives. It is extremely important.

We refer to some case studies in Wisconsin where advocates have gotten into the process of the contracting. It has been critical for protecting consumer rights.

Mr. LINDBERG. Mr. Chairman.

Mr. WAXMAN. Before I get to you, just to follow up on this point, if there were contractual arrangements where doctors pay a certain amount and are put at risk for additional expenditures, which is a clear financial incentive not to provide services, that could be disclosed, but isn't inherent in managed competition itself the idea that a lot of services that some people think, perhaps rightly and sincerely, are unnecessary, overutilized, ought to be withheld so that we are not paying for things that don't really turn out to be cost effective?

Isn't that inherent in the idea of managed competition?

Mr. ROSENBLATT. Yes, I think it is.

Ms. LAW. It is but it doesn't necessarily make it a bad idea to make people pay attention to whether unnecessary services are being provided. It just makes it imperative that there be a process for challenge and dialogue and check and avoiding excessive managed competition, and forcing the competition to be on the basis of efficiency and quality rather than on the basis of denying necessary services.

Mr. WAXMAN. But isn't, when we hear this word efficiency, isn't that really another way of saying, they are just not going to provide a lot of services to people that they think are unnecessary, and what they think is unnecessary may be right in a mega, macro, I should say, point of view, but not for an individual or individual's family?

Ms. LAW. It can be that or it can mean hiring nurse practitioners to do stuff that they are more competent to do than doctors. It can be bad or it can—there are examples of competitive systems that

provide very high quality care, and the trick is to figure out how you set up the structures to make that happen.

Mr. WAXMAN. Well, I was amazed when a group of psychologists came in to see me because I thought if there was any group that ought to be relaxed about going into the new group of competition, it ought to be psychologists and social workers.

They told me they were scared that these systems would be run by physicians who would have a hesitation to rely on the services of psychologists and social workers because of the bias of the physician against them.

How do you evaluate that kind of a concern?

Mr. ROSENBLATT. I think there is some truth to that concern. I think there are pressures in both directions. To the extent the economic theory works, it should lead the leaders of these plans to higher cost effective personnel who can do it.

As Professor Law was saying, it seems to me the critical element is to have enough countervailing regulations and structures that you get the competition over the right sorts of things, which is, of course, the good side of the competition movement.

Mr. WAXMAN. Well, if you are looking at consumer satisfaction, wouldn't most people who are basically healthy, who don't use a lot of medical services be satisfied with a plan that provides them ordinary care and screening, and couldn't it be that they would just not be aware of the fact that if they really got sick, they would not be happy with their plan because the services would not be what they would want them to be?

Ms. LAW. That is why it is not sufficient to rely on consumer reactions in the report card. And I think the question from the social workers goes very much back to your initial question about giving doctors incentives, giving doctors the ability to make money by not providing care.

Rather, we have to give the plans the incentives to provide care in the most economical and high quality way, and if—I think nurses are right to be concerned that if doctors can set up a plan where they will benefit by providing the services and the nurses won't, that there is reason for concern.

But theoretically the plans are supposed to have—to be controlled by somebody other than the individual physicians, I think.

Mr. LINDBERG. Chairman Waxman, in the original Clinton plan draft, there was something called technical assistance foundations and they were taken out before the bill was introduced. The coalition believes that there has to be an external entity in each State that would monitor the quality of care.

Beyond all these protections we want to provide for consumers, we think someone should be doing analyses of under service and under utilization data and report that information back to the regulatory entities, the licensing boards, the—if it is the State insurance commissioners that will be certifying the plans, so that there is—there are negative ramifications for consistently poor behavior in care, and also for not implementing quality improvement programs.

We have talked to a number of experts in the area of quality improvement and one thing that seems clear to me is that most of the quality improvement that goes on saves the plan money. I am in-

terested in what happens when quality improvement for the consumer wouldn't save the plan money and would cost them more, but would be better off—or the patients would be better off.

I think we have to have somebody in each State watching, looking at the data and making sure that when those trends are occurring, that it is reported and reported back to the National Quality Management Council as well so that they can take actions to change the standards as they are needed to be changed.

Mr. WAXMAN. Mr. Rosenblatt, you stated in your written testimony that the development in the insurance and managed care industry of more aggressive utilization review has allegedly led on occasion to serious patient harm and even death.

You cite a number of disturbing cases in which courts have found that patients who are covered through their employers have no remedies for such injuries under State tort laws because those tort laws are preempted by ERISA.

You read the President's bill. It contained no provisions for compensatory or punitive damages in such circumstances.

While the President's bill requires that health plans, as a condition of being offered by an alliance, disclose to consumers the protocols they use to control utilization and costs, it does not establish any substantive requirements that plans use such protocols or that they conform to any minimum standards.

My question is: Do you think disclosure of protocols to consumers is an adequate protection against overly aggressive utilization review, or is judicial review in the case of harm also necessary, and if so, do you think this review should be available in State or Federal Court?

Mr. ROSENBLATT. Yes, I agree that disclosure alone is certainly not enough. It is just common sense that most people, when they sign up for insurance plans, can't possibly absorb the pages and pages of information and fine print, and even if they could, the sense of choice of true voluntary choice is often very weak in that situation, depending on what the different options are.

So I would say that there must be other mechanisms in addition to disclosure, and particularly the judicial review mechanisms are very important, and ERISA is a major block here. Even the National Governors Association yesterday was saying ERISA is a major block to coherent regulation of health plans in the States.

I would just add to this also the importance of judicial review and of the coherent anti-discrimination part of the law also needs significant improvement here, and the special populations that other witnesses have referred to, again, the economic incentives could really cut against them, and it is very important to have clear standards and goals to protect them and judicial review if necessary.

Mr. WAXMAN. Another way for consumers to be protected in terms of quality is that when there is medical malpractice, to bring lawsuits, not just to remedy the person aggrieved, but to try to change the behavior of medical professionals or systems, such as hospitals.

There is a lot of interest in the Congress in trying to limit medical malpractice cases and recoveries because of the fact that medical malpractice lawsuits are driving up the cost of health care in

two ways. One, the cost of premiums are going up, and second, we hear over and over again that doctors particularly are doing things that they wouldn't otherwise in their best medical judgment do for fear that they are going to be second guessed later on.

If we follow the recommendations of those who would like us to limit medical malpractice, what do you think the impact would be on the quality of care? Can we rely on competition with report cards and some regulatory system to take the place of what the medical malpractice system has provided?

Ms. LAW. I think people who have studied this carefully, notably the Rand Corporation, are convinced that we save more in quality improvement by the malpractice system on balance than we spend in the malpractice system, that the malpractice system is worth the money we devote to it, that a lot of the concerns about the malpractice system are overstated.

In fact, we spend a very small proportion of our health care dollar directly on malpractice.

The concern that is often expressed about defensive medicine and malpractice driven unnecessary care is also, I believe, overstated. One person's good conservative medical practice is another person's defensive medicine. But on balance, this is—the malpractice concern has kind of become a scapegoat for a problem that really needs to be addressed in a more systematic way, as the administration's act does.

Mr. WAXMAN. And Mr. Lindberg, do you want to say anything on that issue?

Mr. LINDBERG. Well, the coalition's viewpoint on malpractice is very diverse, and so we have tried to stay away from it and focused on the consumer protections and due process rights that they should have within the system.

Mr. WAXMAN. Well, I think you have given us, both by your oral presentations and your written statements, very important worthwhile information for this subcommittee to consider.

Thank you so much.

I do want to proceed with the last panel, but I want to take a 5-minute break and so don't go too far away and then we will finish up the hearing.

[Brief recess.]

Mr. WAXMAN. For our final panel today, we will focus on the civil and privacy rights protections in the President's proposal, Edward A. Hailes, Jr., counsel, Washington bureau, representing the National Association for the Advancement of Colored People. He is accompanied by Dr. Benjamin F. Jarvis, Jr., executive director and CEO of the NAACP.

Marcia Greenberger is a co-president of the National Women's Law Center in Washington. Tim McFeely is executive director of the Human Rights Campaign Fund and is testifying today on behalf of HRCF, the National Gay and Lesbian Task Force and the National Center for Lesbian Rights.

Kathleen Frawley is director of the Washington Office of the American Health Information Management Association.

We are pleased to welcome you all to our hearing today. Your prepared statements are going to be in the record in full without

objection. What we would like to ask each of you to do is to limit the presentation to no more than 5 minutes.

Mr. Hailes.

STATEMENTS OF EDWARD A. HAILES, JR., COUNSEL, WASHINGTON BUREAU, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE; MARCIA D. GREENBERGER, CO-PRESIDENT, NATIONAL WOMEN'S LAW CENTER; TIMOTHY I. McFEELY, EXECUTIVE DIRECTOR, HUMAN RIGHTS CAMPAIGN FUND; AND KATHLEEN A. FRAWLEY, DIRECTOR, WASHINGTON OFFICE, AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

Mr. HAILES. Good morning, Mr. Chairman, and thank you for the opportunity to present the views of the National Association for the Advancement of Colored People. I am prepared to present the statement of our esteemed chairman, Dr. William Gibson, who is the chairman of the National Board of Directors of the NAACP. He, as well as the entire organization, has a very strong interest in the proposed health care legislation which seeks to improve the health status of all Americans, and this is of particular concern to African-Americans because at present, our health status is quite unequal to that of white Americans.

For a long period of time, the NAACP has had an interest in improving the health care system in our Nation, and we are particularly concerned, after taking a close look at the administration's bill, about what we view as being inadequate protections for civil rights, and so we are making specific recommendations on strengthening those provisions that relate to civil rights protections, anti-discrimination protection.

First, though, I must emphasize that there is a health crisis in the African-American community, and it will take a reformed system to address the urgent need for improvements, and while we discuss and debate today some of the nuances of specific provisions, there are two ultimate questions that we seek answers to. Will the health status of African-Americans, which is significantly unequal to that of white Americans, be improved? And will the new system be free of racial and economic discrimination?

Currently 50 percent of African-Americans are uninsured and at present there are 75,000 excess deaths in the African-American community each year. That is, 75,000 more African-Americans than white Americans die each year from preventable illnesses.

So, indeed, we have to reject the callous notion that there is no health crisis in our community.

The NAACP supports specific changes in the administration's bill. While we support and commend many of the elements of the administration's bill, still we have concerns about the vague and ambiguous civil rights protections.

For example, we are now recommending that there be incorporated in the bill or any health care legislation that passes the Congress a preclearance requirement, a mechanism that ensures that States do not violate civil rights protections. It is an affirmative approach to ensure compliance with existing civil rights laws as well as with the civil rights provisions included in the administration's bill.

Such a preclearance process would require as part of the plan approval process that a State provide specific information about its plan to permit the agency vested with approval authority to determine whether the plan will ensure access to covered services for all segments of the State's eligible population.

States should be required to provide information on the demographic makeup of each alliance area, including the number of residents earning under 100 percent of the Federal poverty level. States should also be required to state the number of licensed and certified health providers in the alliance area, including hospitals, clinics and private physicians and their locations within the alliance area.

They should be required to state whether there are segments of the alliance area that currently lacks a sufficient number of health providers to meet the needs of that community. If such currently underserved communities exist in the alliance area, the State must provide a plan for encouraging providers to locate in these communities and for insuring the continued survival of the health providers currently in these communities.

States should not receive the Federal financial assistance provided under the act unless or until the plans are actually approved, and we note, as you mentioned earlier, Mr. Chairman, that preclearance procedures are currently used and are effective in routing out discrimination.

We view this in one sense as preventive medicine, and that this Nation tends to treat racial discrimination in, if you will, emergency courtrooms when the preventive medicine of preclearance is most cost effective.

Our testimony also recommends other specific areas we think should be strengthened within the administration's bill, ways in which the comprehensive benefits package can and should be expanded improving the infrastructure, and we ask you, Mr. Chairman, to take under consideration and advisement some of the specific recommendations we make in the written testimony.

Thank you, very much.

Mr. WAXMAN. Thank you very much. We certainly will.

[Testimony resumes on p. 491.]

[The prepared statement of Mr. Gibson follows:]

STATEMENT OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

Mr. Chairman and Members of this Subcommittee, I am Dr. William Gibson, the Chairman of the National Board of Directors of the National Association for the Advancement of Colored People (NAACP). I am pleased to have this historic opportunity to present the views of the NAACP on the Health Security Act and, specifically, to address the interests of the African American community as they relate to national health care reform.

The NAACP, founded in 1909, has over 500,000 members, organized into 2,200 branches, youth councils and college chapters throughout the nation. It is the oldest and largest organization devoted to the securing of equal rights and opportunities for African American citizens and other Americans denied equal protection under the law. It is in this regard that the NAACP intends to work with the United States Congress to establish a national health care system that is free of racial and economic discrimination that will, in turn, benefit all Americans.

I offer these views from several vantage points. I am, for example, a health care provider, a civil rights activist, a health care consumer and a small businessman. As a health care provider, I have responded to the oral health needs of my patients often at critical times. As a civil rights activist, I have fought tirelessly to end Jim Crow laws and practices. As a health care consumer, I know the importance of having personal access to quality health care services. Further, as a small businessman, I understand how difficult it becomes at times to address mandates intended to protect employees' interests when confronted with budgetary constraints.

In many ways, my professional and personal experiences reflect the diverse interests of the members of the NAACP. More importantly, I represent an organization that has a long history of seeking and securing equal access to quality health care services and resources for African Americans and other disadvantaged citizens.¹ In the final analysis, I take this opportunity to emphasize that any national legislation which intends to create a

¹ For example, in 1946, Dr. Montague Cobb (who later became the National President of the NAACP) submitted testimony on behalf of the NAACP on the National Health Bill, S. 1606 at hearings held by the U.S. Senate Committee on Education and Labor, (April 16, 1946).

meaningful solution to the current health crisis we face as a nation must effectively address racial and socio-economic realities that exist in our society.

The NAACP has carefully examined the Administration's proposal for health care reform and other proposals as well. We have measured these proposals against health care principles we have embraced.² While we support many elements of the Administration's proposal and commend the Administration for its monumental effort to reform the nation's health care system, we believe that the Health Security Act must be strengthened in several respects to gain our full support. We are particularly concerned that the Act is too vague and ambiguous in addressing important civil rights protections and enforcement mechanisms that are needed to ensure equal access for all Americans.

INTRODUCTION

The NAACP applauds President Clinton for his pledge to veto any health care reform legislation that fails to provide universal coverage. This pledge is significant because a number of health care reform proposals that the NAACP would oppose do not meet this threshold test. On the other hand, the NAACP looks favorably upon a single payer health care system, because it would satisfy this fundamental requirement. It is important to point out, however, that universal coverage does not in every instance guarantee to every citizen universal access to quality health care services.

For this reason, I will attempt to emphasize universal access and coverage issues that are raised by the Administration's bill. Specifically, through this testimony, I will seek to highlight NAACP concerns about areas of the Administration's bill that do not adequately address these access and coverage issues and to recommend specific changes that we believe are in the interest of the common welfare. In this regard, I intend to discuss:

- o strengthening redlining prohibitions, incorporating civil rights preclearance requirements, insuring that effective enforcement mechanisms, data collection and affirmative marketing tools are in place;

² The NAACP convened a HEALTH SUMMIT in July, 1992, bringing together a cross-section of health care experts and NAACP officials to consider the current health status of African Americans and to recommend a set of policies and programs that would improve the health status of African Americans. Later, the NAACP adopted a Health Policy Resolution at its Annual Convention, which set forth guiding principles on health care reform.

- o improving the health care infrastructure and increasing the availability of culturally-sensitive providers and training opportunities in the African American community;
- o removing financial dis-incentives and barriers to health care access;
- o expanding the comprehensive benefits package to guarantee that the specific health needs of African Americans are met; and providing assurances of representation in the bureaucracies created under the Act.

First, however, I must emphasize that there is a health crisis in the African American community. This crisis can only be abated through extreme measures -- we urgently need a substantial reform of the existing health care system. While we discuss and debate the nuances of specific provisions of the current health care proposals under consideration, the NAACP searches for the ultimate answers to the following questions:

will the health status of African Americans, which is significantly unequal to that of white Americans, be improved; and

will the new system be free of racial and economic discrimination.

CIVIL RIGHTS PROTECTIONS

Many African Americans do not receive the health care they need.³ It is clear that race remains a factor in the distribution of health care services. For these reasons, African Americans have a vital need for comprehensive health care reform. Although African Americans are only 12% of the nation's population, almost one third of our nation's poor are African American. In addition, over 16% of those who live in poverty but are above the federal poverty level (the "near poor") are African American. Thirty seven percent of African Americans rely on Medicaid to pay for health services, while currently, 50% of African Americans are uninsured -

³ For example, among senior citizens for whom coronary artery bypass surgery is potentially lifesaving, few African Americans receive the procedure. See, Goldberg, et al., "Racial and Community Factor Influencing Coronary Artery Bypass Graft Surgery..." 267 JAMA 1473 March 18, 1992).

neither eligible for Medicaid, nor employed.⁴

These statistics are vitally important in the context of health care reform since a person's economic status is directly linked to one's ability to obtain adequate health care services. For this reason, it is essential that financial barriers to health services for low income consumers must be eliminated. The statistics alone do not begin to tell the shocking stories that are so familiar to many African American families who face illnesses, diseases and injuries without the financial capacity to acquire needed health services.

These alarming statistics are meaningful standing alone, however, when we recognize that the number of excess premature deaths of African Americans each year is 75,000. In other words, 75,000 African Americans die each year because the existing health care system does not meet their needs. Thus, we are compelled to reject the callous notion that there is no health crisis in the nation.

In order to increase access to covered health care services for African Americans and other traditionally underserved populations, the Health Security Act must assure that States, regional alliances and health plans do not violate civil rights protections under existing civil rights laws, such as Title VI of the Civil Rights Act of 1964, and the civil rights provisions of the Act itself.

Anti-discrimination provisions

The NAACP applauds the Administration for taking steps to address potential civil rights violations. We believe, nonetheless, that the legislation must be more explicit in this regard so that it is made clear that the recipients of federal funds under the Act cannot lawfully engage in practices that have the effect of discriminating against protected populations. Accordingly, the legislation should include stronger, enforceable prohibitions against discrimination. For that reason, the NAACP supports the inclusion of an anti-discrimination amendment that addresses the inadequacies of the present proposal. This amendment would provide the protections necessary to assure meaningful access to quality health care services for every citizen.

Redlining provisions

Further, strong legal protection against redlining on a racial

⁴ S.H. Long, "Public Versus Private Employment-Related Health Insurance: Experience and Implications for Black and Non-Black Americans," in D. Willis, ed. Health Policies and Black Americans (1989), 200, 211.

basis must be a fundamental part of the legislation. Historically, the health care industry has viewed African Americans and low income populations as high risk consumers. Insurance companies admit that "[m]any insurers, if they have the choice, will invest in techniques to avoid...high risk [populations]"⁵ and that "[insurance] carriers in the regional alliances would have strong incentives to avoid attracting high risk individuals."⁶ There are certain safeguards against redlining set forth in the Health Security Act, but additional safeguards are required.

States must have an affirmative obligation to create regional alliances that do not have the effect of discriminating against racial minorities. Also, States must be prohibited from creating racially or economically identifiable regional alliance areas. Moreover, citizens must have an enforceable right to challenge States that, through intention or inattention, permit health plans and health care providers to use policies and practices that appear race-neutral on their face but that have an adverse, disproportionate impact on racial minorities. Simply put, States must be held accountable when the recipients of Federal dollars avoid servicing African Americans and low income populations.

Pre-clearance requirements

A mechanism to ensure that states do not violate civil rights protections is a civil rights "pre-clearance" process. It is an affirmative approach to ensure compliance with existing civil rights laws as well as the civil rights provisions included in the Act. Such a pre-clearance process would require, as part of the plan approval process, that a state provide specific information about its plan to permit the agency vested with approval authority to determine whether the plan will ensure access to covered services for all segments of the states eligible population.

States should be required to provide information on the demographic makeup of each alliance area, including the number of residents earning under 100% of the federal poverty level. States should also be required to states the number of licensed and certified health providers in the alliance area, including hospitals, clinics and private physicians and their location within the alliance area.

⁵ Testimony of Blue Cross and Blue Shield Association, before the Subcommittee on Commerce, Consumer Protection and Competitiveness, Committee on Energy and Commerce, U.S. House of Representatives (Nov. 16, 1993).

⁶ Testimony by the Risk Adjustment Work Group, American Academy of Actuaries, before the Subcommittee on Commerce, Consumer Protection and Competitiveness, Committee on Energy and Commerce, U.S. Representatives (Nov. 16, 1993)

They should be required to state whether there are segments of the alliance area that currently lacks a sufficient number of health providers to meet the needs of the community. If such currently underserved communities exist in the alliance area, the state must provide a plan for encouraging providers to locate in those communities and for ensuring the continued survival of the health providers currently in those communities. States should not receive the federal financial assistance provided under the Act unless or until the plans are actually approved.

Pre-clearances have been used successfully in other contexts to ensure civil rights compliance in federally funded programs, including those programs devised to promote public school desegregation.⁷ The premise was simple. State's should bear the burden of determining how to use federal funds in a way that advances the objective of the federal statute under which the funds were provided, including the end of race discrimination.⁸

It is the position of the NAACP that a similar model can be adopted and modified to ensure equal access to health care for African Americans and other protected groups. Currently, the Act would require states to submit to the National Health Board a "document (in a form and manner specified by the Board) that describes the State health care system that the state is establishing (or has established)." Sec. 1200 (b)(1). The National Health Board is invested with the power to disapprove the state plan if it does not meet the responsibilities for participating under the Act. Sec. 1511(a)(1).

This responsibility would be more appropriately placed with the Department of Health and Human Services (HHS). HHS currently uses a form of preclearance to seek state compliance with federal Medicaid Act requirements. State agencies are required to submit

⁷In the late 1970's the U.S. Department of Health, Education and Welfare's Office for Civil Rights promulgated regulations under the Emergency School Aid Act to ensure that school districts devised their own school desegregation plans, without regard to whether a court ordered a desegregation plan. These regulations led to the creation of over 150 school desegregation plans.

⁸The regulations required a school district or state agency that applied for Emergency School Aid funds to explain how it would desegregate its schools. The Office for Civil Rights (OCR) at the then Department of Health, Education and Welfare had to approve a desegregation plan before the school district's application for funds would be approved and the funds released. OCR worked with school districts to revise plans that were not sufficiently calculated to create a unitary school system.

plans for participation in Medicaid. See 42 U.S.C. Sec. 1396.⁹

These provisions provide the Secretary statutory authority to promulgate regulations and policy guidelines requiring state agencies to indicate, prior to receiving federal Medicaid funds, how their programs will create equal access to quality health care services for people of color and other underserved communities. The same type of pre-clearance can be adopted to ensure states' compliance with applicable federal civil rights laws. To the extent that the Medicaid program will continue to exist, these regulations would still be in effect and states would presumably continue to be required to meet them. As a result, administrative processes would not be duplicated.

Data collection and Affirmative marketing requirements

To further encourage compliance with existing and newly created civil rights laws and to measure compliance with civil rights protections, the Act must provide for the collection of data of access to and utilization of services by protected groups, including racial minorities and low-income groups. Under the current proposal, the National Health Board is required to develop and to implement a "health information system including a variety of necessary information, such as enrollment and disenrollment from health plans, clinical encounters and demographic characteristics of regional alliances."¹⁰ However, the Act does not require the collection of data by race or national origin.

The Act should be amended to provide for the collection of data on utilization of health care services by race, national origin and other groups protected by the civil rights provisions of the Act to measure access to covered services. This information should be collected at the point of enrollment with the regional alliances and on provider billing forms in order to identify point of provider utilization. It must be collected, analyzed and made publicly available. Once this data is available by race, regional alliances, health plans and health providers will be discouraged from discriminating against minorities. Furthermore, regional alliances, health plans and health providers will know what policies or practices should be changed.

⁹ The plan is a comprehensive written statement describing the nature and scope of the state's Medicaid program and assuring that the state will conform to specific statutory and regulatory requirements. 42 C.F.R. Sec. 430.10. Moreover, Congress has delegated broad discretionary powers to the Secretary to promulgate regulations regarding state plans to determine what the state must include in the plan, to review state plans and determine compliance of sub-recipients within the state

¹⁰ See, Sec. 5101 (a) and (e).

There is an important need to prevent the use of any marketing or advertising technique that has the effect of discriminating against groups that are traditionally viewed as "high-risk" consumers. The Act should also create an affirmative obligation to promote the availability of the plan on an equal opportunity basis. Regional alliances and health plans and health providers should not be permitted to discriminate in marketing or advertising. Discrimination in marketing and advertising is often subtle and sophisticated. Therefore, these more explicit protections are necessary.

HEALTH CARE INFRASTRUCTURE

The health care reform legislation must protect existing health care providers and underserved communities. African Americans often do not receive the health services they need because there are not enough physicians, hospitals and other health care providers in African American communities to serve the population. As a result, they rely heavily on hospital emergency rooms for treatment of preventable illnesses or conditions. As Ronda Kotelchick, executive director of the New York Times article, "I don't care what kind of health care card you're carrying, it won't help you if the doctors and facilities aren't there."¹¹

We commend the Administration for recognizing the importance of providing some protection for community health clinics in low-income communities. However, this protection is inadequate. There are no assurances that health plans will contract with minority physicians to serve these communities shunned by other providers. Minority providers should be included as essential community providers and affirmative obligations must exist to include them in the health plans.

We are particularly concerned that health plans will enroll low-income persons and not provide services. As Dan Hawkins, Director of the National Association of Community Health Centers stated, "The fear is HMO's will enroll you, take your money and take their phone off the hook."¹² The legislation must be strengthened to protect "essential providers" and consumers against profiteering schemes that enroll but do not provide health services to poor and minority enrollees.

To further guarantee universal access to quality health care services in the African American community, the NAACP recommends

¹¹ Elisabeth Rosenthal, Shortage of Doctors in Poor Areas is Seen as Barrier to Health Plans, New York Times, October 18, 1993, A1, Col.5.

¹² Jessica Lee, In Inner City, Invasion of the "Body Snatchers", USA Today, October 12, 1993, 10A, Col 1.

that meaningful incentives be available for providers who are committed to serving underserved communities.¹³

REMOVING FINANCIAL BARRIERS TO HEALTH CARE ACCESS

The Administration is to be commended for its focus on reducing financial barriers to health services for low-income consumers. We strongly support, in particular, the guarantee of "blended rates" through which health plans receive the same amount from each participant. This should greatly reduce the extent to which low-income consumers are shunned by health plans.

At the same time, we recognize that certain cost-sharing requirements will prevent many African Americans from seeking and receiving needed health services. All individuals and families, regardless of how little they earn, would have to pay fees for covered health services.¹⁴ They will be required to pay \$10.00 for each physician visit, \$5.00 for each prescription and \$25.00 for each outpatient psychotherapy visit.

Low-income people who are not eligible for Aid to Families with Dependent Children (AFDC) or Social Security Insurance (SSI) benefits, about 40% of the Medicaid eligible populations, and other low-income people ineligible for Medicaid, must not be required to make co-payments higher than those currently allowed under the Medicaid program.¹⁵

Further, many low-income consumers are employed but do not earn enough money to pay health insurance premiums or deductibles required by their employer based health plans, even with the premium subsidy under the Act.¹⁶ It should be clear that the bill fully subsidizes premiums and deductibles for low-income workers

¹³ The NAACP supports provider education and training and incentives for training African Americans, prevention and primary care specialists, and providers committed to health care service in underserved communities.

¹⁴ Health screenings, immunizations, prenatal care and one post-partum visit are excepted from this requirement.

¹⁵ Co-payments for AFDC and SSI beneficiaries will be \$2.00 per doctor visit; \$1.00 for each prescription and \$5.00 for outpatient psychotherapy. This level of cost-sharing is consistent with that currently required under the Medicaid program in states that have cost-sharing.

¹⁶ Some individuals and families would be eligible for premium discounts (Sec. 9102(b)); the federal government would pay a premium subsidy for AFDC and SSI families and families with adjusted incomes below 150% of the federal poverty level (Sec. 6104 (a)(1)).

below 200% of the federal poverty level.

THE COMPREHENSIVE BENEFITS PACKAGE

The comprehensive benefits package should include a minimum of services that respond to the unique health needs of the African American community and that are required for African Americans to live longer, healthier lives.¹⁷ It is unclear whether African Americans and other low-income persons will actually lose health services they currently receive under Medicaid.¹⁸ The legislation should not reduce or eliminate health services currently required by the Medicaid program for all Medicaid eligible individuals.

The NAACP also seeks assurances to ensure that Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services are funded. These services provide comprehensive health benefits to children, including assessment of physical and mental development, immunizations, vision and hearing evaluations and dental care. Of particular concern to the African American community is EPSDT's required testing for and treatment of lead poisoning.¹⁹ Accordingly, we urge you to insure that EPSDT services are adequately funded under the Act.

Further, we encourage you to provide coverage for other specific services that are essential for certain high-risk groups and to provide coverage for necessary testing and diagnostic services for adults. For example, breast cancer is the leading

¹⁷ Pharmacological and pharmacogenetic research studies have revealed, for example, that there exist significant cross-racial differences in responses to medicines. It appears, therefore, that individualized drug therapy, accounting for these differences in metabolism rates, clinical drug responses and side effects, may be essential to quality care for racial minorities. (See, Richard A. Levy, PhD., ETHNIC & RACIAL DIFFERENCES IN RESPONSE TO MEDICINES, 1993).

¹⁸ Currently, Medicaid cover the following services: dental care, eyeglasses and contact lens for adults; rehabilitation and therapy services for congenital conditions or to maintain current functioning; and additional mental health and substance abuse services beyond those covered in the Health Security Act.

¹⁹ Karen L. Florini, et al., Environmental Defense Fund Legacy of Lead: American's Continuing Epidemic of Childhood Lead Poisoning (1990). Lead poisoning is the most common health problem facing children in the United States today. Center for Disease Control, Department of Health & Human Services, Preventing Lead Poisoning in Young Children. (Oct. 1991).

cause of death for African American women under the age of 50.²⁰ Cervical cancer is the second leading cause of death for African American women between the ages of 15 - 34. Black women are three times more likely than white women to develop cervical cancer. Yet, the Administration's bill only covers pap smears and mammograms every two years after the age of 50. These services for women under the age of 50 are sorely inadequate under the Administration's bill. Many African American women will die due to delayed detection of treatable uterine and breast cancer.²¹ These services should be covered when a doctor determines that the patient requires them.

There are certain health services that help to reduce the tragic, debilitating effects of interminable violence. At a minimum the legislation should increase the critical mental health benefits and provide substantial coverage for substance abuse treatment to assist with the reduction and prevention of crime and violence in the communities nationwide, which is having a particularly devastating impact on our children.²²

Finally, the bright future of a reformed health care system that benefits all citizens must include an implementation plan that envisions the representation of all segments of our diverse population at every decision-making level to make certain that the new system is free of racial and economic discrimination.

CONCLUSION

The Administration's health care legislation makes significant strides towards dismantling the nation's dual health care system. Still, it does not adequately address the unique circumstances which negatively affect health delivery for African Americans. The NAACP looks forward to working with this Subcommittee, the Members of Congress and the Administration to strengthen and clarify this critical legislation so that universal access to quality, comprehensive health care will become a reality for African Americans and indeed all Americans. Thank you for this important opportunity to present the views of the NAACP on this historic legislation.

²⁰ National Center for Health Statistics, Health United States (1990), DHHS Pub. No. 91-1232.

²¹ See, Testimony of Cynthia I. Newbille, Executive Director National Black Women's Health Project, before the Government Operations Subcommittee on Human Resources and Intergovernmental Affairs, October 15, 1993.

²² Experts recognize that children who witness violence may experience post-traumatic stress disorder (PTSD), which many war combat veterans experience. This disorder can perpetuate the painful cycle of violence (See, Lori S. Robinson, et al., "Kids and Violence", *EMERGE*, November, 1993, 45 at 46.

Mr. WAXMAN. Ms. Greenberger.

STATEMENT OF MARCIA D. GREENBERGER

Ms. GREENBERGER. Thank you, Mr. Chairman, I am Marcia Greenberger, co-president of the National Women's Law Center. I appreciate the opportunity to appear today. With me is Verna Williams, who is senior counsel with the center, and I am also testifying on behalf of the Women's Legal Defense Fund.

The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect the legal rights and needs of women and their families, and given that focus, nothing is more important to us than health care reform.

We too come from a perspective of a health care crisis for women in looking at this health care proposal. And to begin with, we have to say that we agree that central to eliminating discrimination is looking at the structural provisions in the proposal, and there are key provisions in the administration plan which will go a long way towards eliminating discrimination that women currently face.

Certainly key is universal coverage, not just access, community rating, a comprehensive benefits package, and the like. There are important civil rights provisions in the proposal, but they need to be strengthened to assure that the kind of discrimination women face doesn't continue and isn't perpetuated into a new system.

I am going to very quickly highlight a few of those problems because they do relate to the kind of protection that we think needs to be factored into the plan.

Women and their children are disproportionately represented among the uninsured in this country, including working women, a small percentage of whom have health insurance than do working men. When women have access to a health care system, the care they receive is frequently inadequate.

Insurance plans, both public and private do not provide comprehensive health care for women, especially women of color. As a result, women suffer disproportionately from disease and illness. African-American women, for example, are twice as likely as white women to contract and three times as likely to die from cervical cancer.

Our health care system itself does not provide equal treatment for women and their illnesses. When looking at research, whether it is the type of diseases studied, the subjects of the studies that are being conducted, both the illnesses that women suffer from and including them to determine what kinds of treatments are appropriate has not been adequately dealt with in our health care system currently.

Female patients do not get the same care as their male counterparts. They are 30 percent less likely than men to get kidney transplants, for example. There are many, many more examples in the written testimony that I know is part of the record.

I did have to say in thinking about a question you asked earlier, Mr. Chairman, about whether we will wind up with a two-tier system now under the Clinton plan, when we look for an example in prenatal care for women now that is so sadly inadequate, women are currently suffering from extraordinary rationed care, and it is often the key kind of preventive care that leads to healthy children

that is the most seriously unavailable, especially to middle class women who don't have adequate coverage in their health insurance now.

So I think those most concerned about having pregnancies that are healthy and healthy children have a major stake in this plan.

In turning to the civil rights protections in specific, while there are key improvements here, there are also a lot of inconsistencies. In particular, certain categories protect classes, such as sex discrimination is not always prohibited in the key civil rights provisions. That is one of the most important areas that needs to be improved.

State and corporate alliances, for example, are not prohibited from drawing boundaries in a sex discriminatory way that has particularly adverse consequences for elderly women or women of color, or a boundary if drawn on the basis of age, which is prohibited, could then be defended because it wasn't on the basis of age, but gender, that could be told as a defense to discrimination.

Health plans are prohibited from attracting and limiting enrollment based on characteristics such as health status, gender, race, national origin, as examples, are not listed. They should be.

The health act allows health plans to limit enrollment based on financial stability or lack of capacity. That is one of the structural areas that was referred to earlier where we think that there is potential for abuse and needs specific attention.

Neither sex nor race, for example, are included in the prohibitions against limiting enrollment, and when we turn to some of the business assessing provisions and the civil rights provisions, which are loopholes as they are currently drafted, that can reinforce those kinds of structural problems that you had asked about.

One final thing that I want to refer to, and I certainly endorse the recommendations of the NAACP about preclearance procedures and better enforcement mechanisms in general, but one last thing I want to refer to since the bell has gone off, is the absence of an overall prohibition against sex discrimination comparable to Title 6504 of the Age Discrimination Act and the like which underlie protections for many categories, but because there has been this failure in the law to have an overall prohibition against sex discrimination in the federally funded health care programs, that overriding protection doesn't currently apply and that needs to be inserted as well.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 511.]

[The prepared statement of Ms. Greenberger follows:]



NATIONAL WOMEN'S LAW CENTER

TESTIMONY OF MARCIA D. GREENBERGER, CO-PRESIDENT
AND VERA WILLIAMS, SENIOR COUNSEL
NATIONAL WOMEN'S LAW CENTER
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
ON
THE CIVIL RIGHTS PROVISIONS OF
THE HEALTH SECURITY ACT

Mr. Chairman and members of the Subcommittee, I am Marcia Greenberger, Co-President of the National Women's Law Center. Thank you for the opportunity to appear before you today.

The Center is a non-profit organization that has been working since 1972 to advance and protect the legal rights of women across the country. In particular, the Center focuses on major policy areas of importance to women and their families such as employment, education, income security, reproductive rights, and health care -- with particular attention paid to the concerns of low-income women.

We have been asked to testify on the civil rights provisions of the Administration's health care bill. Civil rights protections in the health care system are crucial to ensure equal access to medical care, particularly for women, who face significant barriers in obtaining adequate health care under the present system. Despite some important advances, such as the creation of the Office of Research on Women's Health at the National Institutes of Health in 1990, women simply do not get equal treatment in our health care system today.

The Administration proposal contains structural reforms which go a long way toward removing some of the major aspects of the system which actually create the problems women face. For example, universal coverage and community rating are absolutely key reforms for women. However, without specific attention to problems of exclusion, disadvantage, and

discrimination faced by women in the health care system, many of their problems will continue.

Barriers To The Health Care System for Women

Women and their children are disproportionately represented among the uninsured in this country. Twelve million women lack health insurance of any kind. Moreover, getting a job is not a sure ticket to getting insurance for women. While 56 percent of employed men have health insurance coverage through their jobs, only 37 percent of working women have such insurance. The reasons for this disparity are linked to the societal discrimination that confronts women. First, women are highly concentrated in service and retail jobs which often do not provide health insurance. Women also comprise two-thirds of part-time workers, who are only 30% as likely as full-time workers to receive health insurance. Finally, women are more likely to receive employer-based coverage as dependents, a benefit that has been cut during these difficult economic times.

Even when women do have access to the health care system, the care they receive frequently is inadequate. Key preventive tests vital to women's health often are inaccessible to women because their insurer refuses to cover the service. Publicly-funded health care, the source of coverage of many women, frequently fails to cover such services as well. For example, many insurers do not cover periodic mammography screening or pap smears, even though these two preventive tests can save lives as well as money because of their ability to detect cancer in its early stages. As a result, many women are faced with the choice of paying for food, clothing, and shelter for their families, or paying for needed medical tests. This failure of the health care system jeopardizes women's lives, particularly those of women of

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color, who suffer disproportionately from disease. African American women, for instance, are twice as likely as white women to contract and three times as likely to die from cervical cancer.¹ With regard to breast cancer, although incidences of the disease are higher among white women, mortality rates for African American women with this form of cancer are 14 percent higher than those for white women.² The disparity in death rates is grim evidence of the impact unequal access to the health care system has upon the most vulnerable members of our society. This inability to obtain comprehensive health care means low income women and women of color will continue to forego health services in order to make ends meet for their families, with tragic results for themselves and for the families they struggle to support.

Moreover, the health care system itself does not provide equal treatment for women and their illnesses. In terms of research, the effects and treatment of various diseases generally are examined as if they only affected men. For example, AIDS, which the Centers for Disease Control identified in 1981, has been striking women -- particularly young women of color -- in growing numbers. However, not until January of 1993, did the CDC expand its definition of the disease to include certain illnesses peculiar to women, such as chronic yeast infections, invasive cervical cancer, or pelvic inflammatory disorders -- a full twelve years into the epidemic. In addition, although nearly 400,000 American women die of heart disease each year, initial studies regarding aspirin's ability to prevent this disease were performed on 22,000 white men and no women whatsoever. The failure even to consider a disease's impact on women

¹Jacqueline Horton, ed., The Women's Health Data Book 49 (1992).

²Id.

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clearly has detrimental implications for the medical treatment they receive and, of course, for their health status.

Research is not the only area in which women's health issues are treated as an afterthought. Studies indicate that female patients do not get the same care as their male counterparts. For example, women are 30 percent less likely than men to get kidney transplants. Men are twice as likely to be tested for lung cancer as are women. A 1979 study reported in the Journal of the American Medical Association found that men received more extensive medical care than did women complaining of identical symptoms (such as back pain, headache, dizziness, chest pain, and fatigue). In 1987, researchers found that cardiologists were ten times as likely to recommend follow-up procedures for men complaining of chest pains than for women after an initial abnormal heart scan.³ Another study showed that, even controlling for various factors, such as abnormal test results, age, types of angina, presence of symptoms, and previous heart attack, men still were almost seven times more likely to be referred for a key diagnostic test -- cardiac catheterization -- than women.⁴ One result of this disparity is that half as many women as men underwent coronary bypass surgery to circumvent clogged blood vessels.⁵ Another diagnostic test -- the treadmill -- remains the primary means of detecting heart disease in women and men, even though there is evidence that the treadmill test is not

³K. Armitage, "Response of Physicians to Medical Complaints in Men and Women," 41 Journal of American Medical Association 2186 (1979).

⁴Council Report, "Gender Disparities in Clinical Decision Making," 266 Journal of American Medical Association 559 (1991).

⁵Id. at 560.

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sufficiently sensitive to identify heart disease in women.⁶

Policies of institutions within the health care system also can serve as barriers to appropriate treatment for women. For example, hospitals frequently prohibit coronary bypass surgery for patients over a certain age. Such policies have an adverse impact on women, however, because women tend to get heart disease later in life.

Other aspects of the existing system disproportionately impact upon women, particularly low-income women and women of color. For example, Latina and African American women bear the burden of providing long-term care more frequently than other members of this society. There are several reasons for this. First, long-term care in nursing homes is expensive -- costing, on average \$30,000 a year -- and, therefore out of reach for poor people, many of whom are Black and Latino. Second, outside help in the form of a nurse or homemaker also is cost-prohibitive. As a result, many African American and Latina women, who frequently are heads of household, have to shoulder the responsibility of caring for a sick relative, in addition to their own children. In addition, since people of color tend to be stricken with debilitating chronic illnesses earlier in life than are whites, these women must undertake the role of caretaker for long periods of time, with little or no prospect of assistance.⁷

Insurers also have charged higher premium rates for women. Some insurance plans also have excluded maternity coverage, and otherwise have had policies detrimental to women's health care coverage.

⁶*Id.*

⁷Laurie Kay Abraham, Mama Might Be Better Off Dead, 151 (1993).

National Women's Law Center, Washington, D.C., January, 1994

From the medical research laboratories where treatments are developed, to the delivery of the treatments themselves, women are second class citizens in the existing medical system, with the predictable unfortunate results for women's health. Any new system will have to be configured to ensure that the discrimination of the present is not perpetuated in the future.

The Reformed Health Care System Under The Health Security Act

We commend the Clinton Administration for moving health care reform to the forefront of the nation's policy priorities to ensure that all Americans have quality health care coverage. The President's plan expands coverage, improves affordability, and goes a long way to integrate women's health needs into the national health care reform agenda. Therefore, the plan provides major improvements for women and it is of extraordinary importance to move it forward. In addition, the plan contains important safeguards to ensure that eligible persons are not denied health care services on account of characteristics such as sex, race, national origin, or perceived health status. However, an analysis of these civil rights provisions indicates that some changes are needed to ensure that the President's goal of universal coverage is actually realized.

In reviewing the relevant provisions, it is important to assess the various actors -- state and private -- and the range of their duties affecting the fair and efficient operation of the reformed health care system. The Act creates the National Health Board, a new federal entity responsible for establishing the components of the comprehensive benefit package, making certain the package is available uniformly to all eligible parties, overseeing cost containment requirements, setting requirements for participating states, among many other things. Other actors include states, which establish the boundaries for regional health alliances and develop

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criteria for evaluating health plans; regional health alliances, which negotiate with state-certified plans to provide service to the alliance area and ensure that all eligible individuals are enrolled as soon as they become eligible; and health plans, which provide the comprehensive benefit package to eligible individuals. Other key players in the Health Security Act include employers, corporate alliances, and health care providers. They could be joined by yet others responsible for key duties as this reform proposal and others work their way through the legislative process. In this regard, carefully drafted civil rights provisions are necessary to ensure that each actor in the reformed system is held accountable for treating all eligible persons equally in terms of access to and provision of health care services.

Civil Rights Protections and Public Accountability

The Act presently contains several civil rights provisions designed to preclude the myriad of actors from using impermissible biases to deny eligible persons access to health care or provision of health care services. States are prohibited from discriminating in drawing the boundaries for regional alliances. Section 1202(b)(4). In turn, alliances may not discriminate against health plans. Section 1328(a). Health plans must accept all eligible individuals for enrollment. Section 1402(a)(1). Additionally, health plans may not discriminate. Section 1402(c)(1). Employers may not discriminate against employees on the basis of family status. Section 1605. As these provisions indicate, cognizant of the interplay among the various actors in the plan, the Act seeks to ensure that the goal of universal coverage is achieved, by properly establishing the responsibilities of the various players in this new system. However, some provisions accomplish this goal more effectively than others.

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In particular, the provision that prohibits discriminatory behavior on the part of health plans appears to be the most complete in terms of the protections it provides. This provision generally prohibits discrimination on the basis of race, sex, national origin, language, socio-economic status, age, disability, health status or anticipated need for health services. However, while even this provision has some omissions, the other provisions are more of a patchwork and as a result improvements are clearly needed.

Inconsistencies in Protected Groups

The civil rights provisions are not consistent throughout the Health Security Act. Specifically, the classes protected by the various provisions change from section to section, without any clear rationale.

1. States are prohibited from discriminating in establishing boundaries on the basis of race, age, language, national origin, socio-economic status, disability and perceived health status. Section 1202(b)(4). Similarly, corporate alliances may not establish premium areas based on race, age, language, religion, national origin, socio-economic status, disability, or perceived health status. Sex is not among the protected classes. These omissions could have serious implications for women in general, and for low-income women in particular. As written, these provisions would allow a state or corporate alliance to exclude from an alliance or premium region an area comprised primarily of elderly women or women of color, for example. The state or corporate alliance could justify its action by stating it did so on account of sex, rather than age or race. Such a result is simply untenable.

2. Elsewhere in the Act, health plans are prohibited from attracting or limiting enrollment based on characteristics "such as" health status, anticipated need for health care, age, occupation, or affiliation with any person or entity. Section 1402(a)(1). Sex, race, and national origin are not among the protected classes for this section. Although the protected classes included in this provision apparently are listed for illustrative purposes and not to suggest the exclusion of other classes, categories including race, sex, and national origin should be added to put plans explicitly on notice that those types of discrimination also are prohibited.

3. The Act allows health plans to limit enrollment based on financial stability or lack of capacity, provided the limitations are not made on the basis of health status, anticipated need for health care, age, occupation, or affiliation with any person or entity. Section 1402(a)(2). Again, neither sex nor race for example, are included in this provision. As a result, a plan could blatantly limit the enrollment of women on the grounds that lack of capacity or financial stability required the action.

4. In addition, health plans may not discriminate against a health care provider because of certain characteristics of the provider's patient, namely socio-economic status, disability, health status, or anticipated need for medical services. Section 1402(c)(2)(A). Once again, race, sex, or national origin are not included. Exclusion of these protected classes means, for example, that providers who treat low-income women of color could be left out of a health care network, a very possible result since these patients frequently suffer from ailments that require long-term expensive care. Moreover, by permitting these types of discrimination, the Act inadvertently creates a disincentive for providers to care for members of underserved

groups. Accordingly, this provision also should be expanded to include sex, race, and national origin.

5. In regulating the transition period when the reformed health care system is to be phased in, the Act prohibits self-insured plans and employers with group insurance plans from discriminating among employees in establishing a waiting period before making health insurance coverage available based on the employee's (or dependent's) health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability. Section 11005(b). Sex, race, and national origin for example, again, are excluded from this provision. While Title VII would cover discrimination in this regard for employers with more than 15 employees, clarifying the prohibition for all in the Act is important. There is a similar problem with respect to Section 1605.

6. The Act provides that regional alliances are recipients of federal funds for purposes of Title VI of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, and Section 504 of the Rehabilitation Act, which prohibit discrimination based on race, religion, national origin, age, and disability in programs receiving federal funds. Section 5239. While a number of statutes prohibit sex discrimination in specific federally-funded health care programs,⁸ since there is no comparable broad-based anti-discrimination statute prohibiting sex discrimination in federally funded programs, as currently drafted women are excluded from

⁸For example, federal programs such as the Maternal and Child Health Service Block Grant, 42 U.S.C. § 701 *et seq.* (1992), and the Preventive Health and Health Services Block Grant, 42 U.S.C. § 300w-7 (1992), have provisions that prohibit discrimination on the basis of sex.

the protection of this provision. In order to ensure that sex discrimination is not permitted in any health program receiving federal money, this provision must be modified.

The rationale for making a reference to regional alliances but not including other actors in this provision is unclear. The Act authorizes actors other than alliances to receive federal funds. For example, academic health centers, hospitals, and other individuals or entities may receive federal funding, Section 1513, as may states, under the Act. Sections 1515(a)(1) and (b)(1). Thus, this provision should be broadened to prohibit any and all entities receiving federal financial assistance, including under the Act, from discriminating in providing access to health care services or in providing the services themselves on protected bases, including sex.

As the foregoing suggests, the inclusion of protected categories in some parts of the Act but not others is confusing and problematic. As drafted now, the plan prohibits sex discrimination, in some circumstances and not others, without explanation or rationale and with serious adverse consequences to women's health. Therefore, the Act should state explicitly and consistently throughout that discrimination on the basis of sex will not be tolerated in health any longer.

Lack of Clarity Concerning "Business Necessity" Defense

The key protections afforded by Section 1402(c)(1) concerning the actions of health plans are called into question by the "business necessity" defense provided in the bill. Pursuant to Section 1402(c)(1), health plans may not engage in actions that discriminate against eligible persons on the basis of sex, race, and national origin, among others. This section of the Act also permits a "business necessity" defense, which as drafted will result in confusion. See

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Section 1402(c)(3). First, this concept was developed in the context of Title VII, and generally does not appear in the text of federal non-discrimination statutes otherwise. It is of questionable application in the context of health care. Second, as drafted, it does not reflect basic principles of the defense as it has evolved even in a Title VII context, clarifying, for example, that the defendant has the burden of proof and what the elements of this defense contain. It is important that this area be clarified to avoid plans' ability to circumvent the proscriptions against discrimination by merely asserting that the cost of complying with the Act was too great, or that they are simply oversubscribed with members of one gender or one race to be more inclusive.

Failure to Apply to National Health Board

The National Health Board, does not appear to be subject to any provision directing it to operate in a nondiscriminatory manner. Given the important duties of the Board, the Act should provide a safeguard to ensure that the Board does not take actions which discriminate against women, people of color, and others in their access to health care. The Act must provide such protections explicitly so that the promise of quality health care is available to all eligible persons.

Absence of Internal Measures to Ensure Compliance

1. National Health Board

The civil rights provisions lack internal measures to ensure that all actors in the reformed health care system are in compliance with the anti-discrimination sections. For example, the National Health Board must review documentation of the states prior to funding their health care systems; however, nowhere in this "pre-clearance" process is the Board directed to evaluate a

state's plan to provide services to all its inhabitants in a nondiscriminatory manner. States should be required to submit their proposed alliance boundaries to the Health Board, for example, with demographic and economic data concerning the protected populations to ensure the alliance boundaries have not been drawn in a discriminatory manner. In addition, states' documentation to the Board should demonstrate that alliances and health plans operating within their systems will provide health care services to underserved populations, in conformance with the anti-discrimination provisions. Such a requirement is necessary to ensure the Act's goal of universal coverage is realized.

2. States

Similarly, the Act should explicitly require states to evaluate and certify health plans on the extent to which they comply with anti-discrimination principles. The Act implicitly directs states to include the nondiscriminatory mandate in establishing their criteria for evaluating plans. Section 1203(2)(D). However, the extent to which plans provide services to all eligible persons is the cornerstone of the Act, compliance with the anti-discrimination provisions should be as prominent a criterion as financial stability or quality. Similarly, the state should be directed explicitly to evaluate the health plan's ability to adhere to the anti-discrimination provisions and empowered to "de-certify" plans that do not meet the state's criteria with regard to nondiscrimination. No such mechanism exists under the Act presently.

3. Lack of Plan Accountability

The Act allows health plans to limit enrollment under certain circumstances, but provides no means for ensuring that this authority is not used in a discriminatory manner. As stated

previously, plans may limit enrollment under certain circumstances. Section 1402(a)(2). There is no provision requiring the plan to justify its decision to limit enrollment however, to ensure that "financial stability" or lack of capacity is not merely a smokescreen for discrimination. Moreover, there is no means for the alliance, the state, or any other entity such as the National Health Board to monitor such decisions by examining the basis for the limitation and requiring plans to demonstrate how proposed limitations on enrollment would improve the plan's financial stability, for example, or by requiring the plan to determine which populations would be adversely impacted upon and provide a comparable alternative for them. Such mechanisms are necessary to prevent plans from using these exceptions to circumvent the universal coverage purposes of the Act.

Similarly, there are no safeguards to ensure that health plans establish "enrollment priorities" in a nondiscriminatory manner. Such priorities are necessary in the event that a health plan "does not have sufficient capacity" to enroll all eligible persons. the Act requires Section 1323(f)(1). The Act provides no indication of what constitutes "sufficient capacity." Nor does it require plans to review the health plan's enrollment priorities to ensure they are not based on discriminatory factors. In failing to provide such protections, the Act lacks a means of ensuring that the plan is not turning away low-income women of child-bearing years, for example, under the guise of "insufficient capacity."

No Data Collection Provisions Relating to Civil Rights

Although the Act provides for extensive data collection regarding enrollment, utilization, outcome, health care provider certification, and consumer satisfaction, there is no provision

concerning the collection of gender, race, or other key data. Such information is crucial in monitoring the various actors of the reformed system to ensure that the alliance boundaries are not drawn in a discriminatory manner, for example, or that an alliance had adopted enrollment priorities that excluded women or people of color. Such data is critical to determining whether plans are in compliance. Thus, the Act should require the compilation of data according to race, ethnicity, gender, and other protected categories with the maintenance of such data in a uniform format that would be accessible to the public, as well as the government for enforcement purposes.

Similarly, the Act lacks provisions that ensure that research is conducted in a nondiscriminatory manner. The Act requires the director of the National Institutes of Health to ensure that NIH conducts and supports research to promote health and prevent diseases such as breast cancer, and placing reproductive health among its priority items. Section 3201(2)(A) and (B). However, without a prohibition against sex discrimination, there is no protection to assure that other diseases afflicting women in large numbers, such as cervical cancer or lupus, will be studied fairly. In addition, there is no provision to ensure that research is conducted on women subjects. As mentioned previously, many studies have examined illnesses such as AIDS or heart disease as if they only affected white men. Clearly, failure to consider women as we seek out cures and assess treatments of disease can only have negative consequences for the health care women ultimately receive. Thus, inclusion of women and the diseases affecting them is necessary for the Act to ensure that this aspect of women's health is protected.

Problems with Enforcement Scheme

While there is a detailed enforcement mechanism similar to those under other federal civil rights statutes available to persons with grievances against discriminatory health plans, there are no such comparable provisions for parties with complaints against alliances or other actors. In brief, the Act permits persons with grievances against plans to bring an action directly in federal court. In addition, if the Secretary of HHS finds that plans have discriminated, she or he may take appropriate enforcement action, or refer the matter to the Attorney General. In contrast, although persons aggrieved by an alliance's failure to enroll them may bypass the administrative procedures and bring an action in federal court,⁹ there is no provision for intervention on the part of the HHS Secretary or Justice Department for those alliances that engage in a pattern or practice of discriminatory enrollment or disenrollment.

The Act also lacks provisions that specifically are geared toward discriminatory actions by the state or National Health Board. With regard to the National Health Board, the Act provides states or alliances that have been harmed by the Board with an opportunity to have the court review the Board's action; there is no similar provision for a private individual that is aggrieved by the Board. Private persons should be permitted to challenge Board actions that discriminate against them, such as cases in which the Board permits a state to discriminate in drawing alliance boundaries or when the Board itself alters the comprehensive benefits package in a biased way.

⁹Other exceptions to the requirement to exhaust remedies include cases in which the issue is whether the person is eligible for coverage, eligible for a premium discount, or eligible for a reduction in cost sharing. Section 5237(b)(2)(A), (B), and (C).

Public Accountability

The Act establishes new boards, governing bodies, and other entities to oversee and administer the reformed health care system. Although the criteria for selection of members is broad in some respects, the Act lacks requirements to ensure diversity, including that women are represented among the members. For example, criteria for serving on the National Health Board include expertise and experience in areas such as medicine, nursing, financing and delivering state health systems, and delivery of care to "vulnerable populations." Section 1502. Because many persons have needed expertise and experience, without a provision that diversity of gender, race, and ethnicity, among other categories must be among the criteria used in selecting the Board members, in addition to a demonstrated ability to provide health services to underserved populations, the range of needed expertise may not be present.

Similarly, diversity should be a consideration in staffing the numerous advisory committees to the Health Board, regional alliances, and governing boards. Representation by women and other protected categories is crucial to assuring that issues of concern to all are addressed.

Conclusion

The Health Security Act is an important step in reforming the health care system and providing access and universal coverage to the people of this nation -- particularly women who historically have been underserved. Of course, the structure of the plan itself will play a large role in ensuring that discrimination does not occur in the first instance --

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- ▶ Guarantee of universal coverage to everyone;
- ▶ Elimination of workforce participation as the key to obtaining health care coverage;
- ▶ Continuous health coverage, despite a change in jobs or a move to a new area;
- ▶ Existence of meaningful subsidies to low-income persons; and
- ▶ Elimination of cost to consumer for preventive services.

These features are critical to ensuring that women no longer are denied needed health care or access to the health care system.

But in addition to these aspects of the Act which are of enormous importance, there is a need to assure that the reformed health care system is not marred by the discrimination that exists now. Accordingly, we urge the Subcommittee to review the civil rights provisions in light of the concerns that we have raised today and revise them so they provide a clear and coherent statement that effectively precludes discrimination and provides strong measures to address bias in any form in which it may appear.

Mr. WAXMAN. Mr. McFeely.

STATEMENT OF TIM McFEELY

Mr. McFEELY. Mr. Chairman, I am Tim McFeely, executive director of the Human Rights Campaign Fund.

I will present the views of four national lesbian and gay rights groups devoted to securing equal access to health care for our constituents, the American Association of Physicians for Human Rights, the National Center for Lesbian Rights, the National Gay and Lesbian Task Force, and the Human Rights Campaign Fund.

Thank you, Mr. Chairman, for allowing us the time to present our views. I want to express our appreciation for the leadership of the President and the First Lady and of this committee in addressing the crisis in America's health care system, and we believe it is a crisis, Mr. Chairman.

We support the President's determination to enact meaningful reform as well as principles which he has put forth to the American people and to this Congress. We share his commitment to invest in preventive education and health services, treatment for mental health and substance abuse, long-term care, prescription drug coverage, and other proactive policies to promote good health and reduce medical costs in the long run.

Investment in an aggressive national program of biomedical research, especially as it addresses women's health needs, HIV, AIDS, and other infection diseases will pay rich dividends for our future.

In his State of the Union address, President Clinton made it very clear that one principle rises above all others, that is that every American must be included. We are all in this together. Indeed, the crisis arises largely because the current health insurance system denies that simple fact and continues to break us into smaller and smaller categories and subcategories. It divides us. It splits us into factions. The insured, the underinsured, and the fastest growing faction, the uninsured, and it has failed.

Mr. Chairman, the President closed his speech by observing that in the worst times, the American people come together, and that is exactly what we must do to solve this crisis, come together, pool our risks, and move forward.

There are still those, including Members of Congress, who deny there is a health care crisis. Well, I guess whether or not you recognize a crisis sometimes depends on where you sit. At this time last year, I and the other employees of the Human Rights Campaign Fund believed we were secure in the health insurance coverage offered to us through our job. Then the company that is insuring us went bankrupt.

We have spent months trying to obtain new coverage, but company after company and broker after broker tell us that we are too small and have too many claims. In our case, the claims have been rendered—the claims that have rendered us ostensibly uninsurable have been a result of HIV, AIDS.

For other small employers, other catastrophic conditions put them in the same crisis. Yes, it is a crisis. So, Mr. Chairman, if your colleagues deny that there is one or do not believe that it is

literally impossible for some small employers to purchase coverage, I would appreciate their help in finding health insurance.

Meaningful reform must provide access to quality care for all Americans, all of us, on a nondiscriminatory basis. Documented experiences of the lesbian and gay community in the current health care delivery system demonstrate the need to include us in the anti-discrimination provisions of the law you enact.

The bill as it is currently drafted does not prohibit discrimination based on sexual orientation. It should. Insofar as the President and leaders in Congress have acknowledged that discrimination is a factor in the provision of health care coverage, we must protect all who are likely to face discrimination within the health care setting. This includes lesbian and gay Americans, who are as likely as any group to be denied equal access to care.

We are also concerned that the so-called conscience clause is too broadly drafted and will result in discrimination against lesbians and gay men on the basis of a provider's narrow view of morality. This should be changed.

Our specific recommendations are incorporated in the written testimony we have provided the committee. The President's initiative presents us with an historic opportunity to address the health care needs of every member of the American family.

Mr. Chairman, we must not miss this opportunity or leave anyone behind.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 524.]

[The prepared statement of Mr. McFeely follows:]

TIMOTHY I. MCFEELEY
EXECUTIVE DIRECTOR
HUMAN RIGHTS CAMPAIGN FUND

Good morning. I'm Tim McFeeley, Executive Director of the Human Rights Campaign Fund. I am here today to present the views of four national lesbian and gay rights groups devoted to securing equal access to health care for their constituents: the American Association of Physicians for Human Rights, the National Center for Lesbian Rights, the National Gay and Lesbian Task Force and the Human Rights Campaign Fund. Thank you for allowing us time to present our views.

We share the position of President Clinton and the majority of Americans that accessible and affordable health care is one of the most far-reaching social and economic problems facing our nation today. We are on the side of those who know that the health care system is in crisis and has been that way for some time now. According to the Health Care Financing Administration, Americans will spend \$1 trillion on health care in 1994. The ability of the 103rd Congress to enact comprehensive health care reform will have profound implications on America's ability to be competitive in a world economy and to increase the economic and personal security of every American.

Our organizations represent millions of lesbians and gay men whose needs have been overlooked by the mainstream health care delivery system. Until the emergence of the AIDS epidemic, little was known about the broad range of health concerns of lesbians and gay men -- which remain extensive and unmet. Although

lesbians and gay men share the same health care reform concerns as all Americans: cost, quality and access, we also have medical conditions and issues that affect us especially, though not exclusively. There are high rates of chronic, life-threatening diseases in our communities --including HIV/AIDS, cardiovascular disease, breast and gynecological cancers. Many lesbians and gay men have special confidentiality concerns in their workplace or communities which can be negatively impacted by their health care situations. Our most intimate family relationships are generally not considered by the health care system nor recognized by our legal system.

We applaud the President, Mrs. Clinton, and Members of Congress for their leadership and willingness to address such a complex issue. This Administration recognizes that America must begin to invest in preventive education and health services, treatment for mental health and substance abuse, long-term care, prescription drug coverage and other proactive policies in order to promote good health and reduce medical expenditures in the long run. Investment in an aggressive national program of biomedical research, especially as it addresses women's health needs, HIV/AIDS and other infectious diseases, will pay rich dividends for our future.

The Health Security Act presents us with the first opportunity in many decades to include the needs of all Americans, including lesbian and gay Americans, into the health care delivery system of our country. Today, I would

like to share with you some of the areas of major concern to my community as we begin this historic national debate.

ANTI-DISCRIMINATION PROVISIONS

We support the President's pledge that meaningful health care coverage must provide equal access to health care for all citizens on a non-discriminatory basis. This principle is of particular importance to lesbians and gay men because of the insidious reality of discrimination in the actual practice of providing such services. We are gratified that we have reached a stage in the public discourse on HIV/AIDS and other disabilities, that the Health Security Act specifically provides for protection against discrimination for disabled persons, those who are perceived to have a disability or who may be at a high risk for becoming disabled. However, this protection clearly does not extend to those in the lesbian and gay community who are not infected by HIV or AIDS or who might not have any other disability.

The experiences of the lesbian and gay community, as recounted in a soon to be released report by the American Association of Physicians for Human Rights (AAPHR) substantiate the need to include lesbian and gay citizens in the anti-discrimination provisions of any health care reform proposal. A study in Michigan showed that 60% of the lesbians have not revealed their sexual orientation to health providers for fear of breaches of confidentiality and discrimination. Other

studies show another side of the issue - discrimination against lesbian and gay health care providers by other players in the health care system. As discussed in the AAPHR report, one study of 930 San Diego County physicians reported that 30% of those questioned stated that they would not admit a highly qualified applicant to medical school if they knew the applicant was lesbian or gay. Forty per cent of those physicians surveyed admitted that they would not refer patients to a lesbian or gay colleague. Lesbians and gay men must have the right to full health care coverage free of bias on the part of health alliances, plans or providers.

We propose two changes to the current plan which we believe will lend consistency to the anti-discrimination provisions currently in the bill and will make the bill more inclusive of lesbian and gay citizens. Currently, the anti-discrimination provisions sprinkled throughout the bill (for example, Title I, Subtitle C, Sec. 1202 (b)(4) prohibiting health alliances from discriminating in establishing boundaries; Title I, Subtitle D, Sec. 1328 prohibiting health alliances from discriminating against health plans; and Title I, Subtitle D, Sec. 1402 (c)(1) prohibiting health plans from discriminating) differ significantly in terms of the protected categories listed. While such language was undoubtedly intended to distinguish between the activities of the regional alliances and those of the health plans, we fear that this dilutes the clear intention of the Act that all Americans be able to attain adequate health care. We propose that these various provisions be replaced with one uniform provision which combines the protected categories and bans discrimination in all facets of the proposed plan.

Second, we propose that sexual orientation be added to the uniform provision banning discrimination. Without a strong and inclusive anti-discrimination provision in the Health Security Act, the practice of discrimination against lesbian and gay providers and patients will only be perpetuated. Insofar as the President and Members of Congress have already acknowledged that discrimination is a factor in the provision of health care coverage, we should not stop short of protecting all who are likely to face discrimination within the health care setting. This includes lesbians and gay men who, directly or indirectly, are as likely as any group to be denied equal access to meaningful health care by alliances, plans or providers.

Thus, we propose that the various anti-discrimination provisions be replaced by one uniform, inclusive provision that applies throughout the plan. The provision must state that no health plan or health alliance may engage (directly or through contractual arrangements) in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of race, national origin, gender, sexual orientation, religion, disability, income, health status, or anticipated need for health services.

CONSCIENCE CLAUSE

Title I, Subtitle C, Sec. 1162 provides that "A health professional or a health facility may not be required to provide an item or service in the

comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction." This language is so vague that the possibilities for abuse are great.

No health plan should in any way allow an opening for health care providers to refuse services included in the benefits package. Allowing providers the chance to refuse otherwise guaranteed services based upon "moral conviction" simply cuts too broadly. While on its face this provision attempts to reach certain procedures (like abortion), there is nothing that would prevent a provider from invoking this procedure in order to deny services to lesbians and gay men who are still perceived by many to be immoral. By what standard will we determine whether one person's moral conviction allows the refusal of services, while another's does not? The lesbian and gay community has a particular concern with such a provision which will undoubtedly allow institutions, whether religious or secular, to turn us away based upon no higher standard than stating a moral conviction that homosexuality is wrong. Therefore, we propose that moral conviction or religious belief never be a basis upon which a facility or individual provider may deny services to an individual or group of individuals.

Additionally, we submit that facilities themselves are not capable of having moral or religious convictions. They should not be allowed, therefore, to invoke such convictions in order to avoid performing services that are otherwise guaranteed to all citizens. We acknowledge, however, that the government may

not require legitimate religiously owned and operated institutions to perform services that violate the religious beliefs of the group. Our proposed amendments would allow religious institutions to refuse such services or items, but only based upon their religious beliefs, not the more tenuous moral convictions. While this may mean that a Catholic hospital may not be required to distribute condoms as a public health measure, they must not be allowed to refuse treatment in general to lesbians or gay men, pursuant to the anti-discrimination language we hope this Subcommittee will adopt.

FAMILIES MATTER

Families are a crucial component in one's ability to access comprehensive health care. How, but for family members, would most of us get to the doctor's office or the hospital? How would most of us take care of ourselves when returning home from the hospital or outpatient surgery but for family members who care for us? And how, even with health coverage, would most of us pay for the additional costs of health care if we could not rely on family members to help us? Were it not for the millions of family members who assist voluntarily when we are ill, the burden on our system would be far greater. Without families, it would be much more expensive for patients and health care plans to cover the transportation, home health services, pharmacy delivery charges, day care and other costs related to health care.

Family members provide this support and care regardless of whether they are families by law, by blood, or connected by love and commitment. In recognition of the important contributions that families make to the well-being of the individuals involved, many state and local jurisdictions are beginning to expand the definition of family to include those not defined by blood or law. Yet, the current plan places a greater, and unfair, burden on so-called non-traditional families.

Title I, Subtitle A, Section 1011 of the Health Security Act states that a goal of the plan is to ensure that every married couple and their biological and/or legal children are enrolled in the same plan, recognizing the practical need that families have to share medical resources and that treatment of many medical illnesses and mental health needs is best provided using a whole family model. Unfortunately, the Health Care Security Act fails to account for the millions of families living in this country who are not related by marriage, adoption, or blood ties, but who nonetheless share the same household and the same need to coordinate their health care coverage. These families must each pay individual deductions of \$1500 per person rather than the family deduction of \$3000. Additionally, these families are denied the opportunity to treat their deductible in the aggregate.

Unless they are specifically included in plan, members of non-traditional families will be unable to participate in collateral mental health services, such as

family counseling for substance abuse or commonly prescribed mental health therapies. They will also be denied the lower family premium rate and, if a plan is full, would not be entitled to enroll in the same plan as other family members. This omission would not only affect unmarried partners living in the same household, but would also impact negatively any children who are not related by blood or law. For these reasons, we strongly urge that the definitions of family that appear in Title I, Subtitle A, Section 1011 be modified to include a more accurate and comprehensive definition of family.

HEALTH CARE REFORM FOR PEOPLE WITH HIV/AIDS

Health care reform is of particular concern to people with chronic, life-threatening illnesses, especially those people with HIV infection or AIDS. While the issues we have raised at the beginning of my testimony will have an impact on those lesbians and gay men who suffer discrimination because of their sexual orientation, we must not omit the devastating impact that HIV/AIDS has had on the lesbian and gay community, as well as all Americans, when discussing health care issues.

The Health Care Security Act will provide accessible, affordable, and, we hope, non-discriminatory health care coverage to every American. Confidentiality of medical records must be broadly protected in any health care package. For

people with HIV infection, medically necessary early intervention services are vital to long term survival and quality of life concerns. Those people with affordable, portable and permanent insurance are more likely to seek early medical treatment than those in less secure situations. HIV/AIDS prevention efforts are hampered by those unaware or unable to access the health care system due to cost or fear of discrimination. Non-discriminatory coverage also means an end to AIDS benefit caps, red-lining, HIV testing and screening by insurers.

Any meaningful health care reform bill must offer a package of comprehensive benefits which promotes prevention, primary care and efficient use of health care dollars. Long-term care, home and community-based health care, and prescription drug coverage are all necessary components of cost effective health maintenance and critical care for people with HIV/AIDS. Increased investment in biomedical research will lower the cost of medical care for people with AIDS and other diseases over the long run and should be aggressively funded in any national health care plan.

The U.S. must invest in targeted medical education so that physicians are trained to provide HIV-related care to all populations, including women and children. Delays in diagnosis and appropriate treatment lead to increased illness and mortality as well as unnecessary escalation of medical costs. Investment in prevention education, disease surveillance and other public health measures must be appropriate as a cost cutting measure over the long term. Explicit and

culturally relevant HIV/AIDS prevention education is imperative and must be available to every American.

CONCLUSION

In conclusion, we support the broad principles outlined in President Clinton's Health Security Act and believe strongly that meaningful health care reform must provide equal access to care for all Americans. Congress and the President have the historic opportunity to include the needs of every American in the health care delivery system of this country. I would encourage this Subcommittee to consider our suggestions today for inclusion in the final version of this landmark legislation. As lesbian and gay Americans, we are all in this together, and we must work together to provide a solution to a crisis of profound proportions for the social and economic security of us all.

Mr. WAXMAN. Mr. Hailes, I am intrigued by your suggestion that the President's bill be amended to include a preclearance process under which the Secretary of HHS would review the alliance boundaries drawn by a State to assure that sufficient providers are available to low-income and minority communities. Can you elaborate on how this might work in practice?

Isn't there some danger that this will just evolve into a mechanism for systematically waiving existing statutory protections, as has happened to Medicaid beneficiaries and community-based providers in Oregon and Tennessee?

Mr. HAILES. Thank you for the opportunity to respond to that, Mr. Chairman.

I think we can build upon the experience that we now have, with the dangers and the problems, with the manner in which those waivers have taken place with regard to Medicaid. The idea here is to make certain that States give information to HHS about how they are going to implement the—this new reform package in their States and how they are going to address the specific needs of targeted populations, including African-Americans and other disadvantaged populations.

The way we think that it could be aided this time is to make it certain that in addition to preclearance, I have a data collection requirement which would show utilization patterns or would at least project how those utilization patterns would take place. Having HHS receive that information, and it becomes publicly disclosed, would give advocates an opportunity to point out how their communities would be served. So while we think that the Medicaid experience has not been good in all instances, we think that we can look at those Medicaid experiences and correct some of the problems that existed.

Mr. WAXMAN. I would like to ask Ms. Greenberger to comment on how this might work in practice, and what your concerns may be about this whole thing turning into a mechanism for a systematic waiver like we have seen in Medicaid, for existing provisions on community-based providers in Oregon and Tennessee?

Ms. GREENBERGER. Well, we have also seen some preclearance failures in the context of civil rights enforcement with the Department of Labor, and the Office of Federal Contract Compliance Programs as well, where it has turned into really a meaningless exercise.

I agree with Mr. Hailes, that it is a very doable thing if it is set up and done properly. I think it is inextricably bound to the proper kind of data collection. And one of the things that is particularly important that is missing now, is that if you don't ask the right questions, you are never able, whether it is in the beginning, the middle or the end of the process—and there is not even a decertification mechanism right now with proven problems in place, if we don't have data collection systems that ask these questions from the very beginning, then we can't have a preclearance process that works or anything else further along the line.

If we do have proper data collection from the beginning and we do have people charged with the responsibility of thinking about and looking at these issues from the beginning, then I am not saying that it would be foolproof, but I think it would make an enor-

mous difference in the mind-set from the outset. And I do think that it can work, especially if it is viewed as important an obligation as other obligations, such as financial stability, which is, in essence, expected to be reviewed from the beginning.

Mr. WAXMAN. Ms. Greenberger, short of amending the relevant provisions of the civil rights laws, is it sufficient to add gender to various provisions of this bill as an illegal basis for discrimination?

Ms. GREENBERGER. Well, I think that it can be. There just needs to be a broad-based prohibition against sex discrimination in federally funded health care that can apply to the provisions funded specifically here, but especially because, as we have heard with public health systems and with other parts of the health care system, some of it will be funded directly through this program. Others might be funded in somewhat different ways. And so I think it is important not to amend the other laws, but in this particular context, to make sure that we have a broad-based nondiscrimination prohibition that deals with sex discrimination in health care.

Mr. WAXMAN. Mr. McFeely, since the discussion of nondiscrimination gets muddled very quickly, let me ask this question point blank: Are you and the groups you are representing asking for any special treatment or special rights under this health plan or are you asking to be assured that gay men and lesbians are treated just as everyone else is?

Mr. MCFEELY. We want equal access. We are not asking for anything special. No one that I am representing certainly is. What has happened to our communities—members of our community in the past, has been that we have faced discrimination. We find that providers do discrimination against lesbians and gay men, and as a result, we are an underserved community. As a result of that underservice, of course, we see health care costs rising, and just a basic unfairness.

So, no, Mr. Chairman, we are asking for equal access. We would like it written into the provisions of this act.

Mr. WAXMAN. Well, I thank all of you very much. I think you have been very helpful to us in your testimony and we look forward to working with you.

I understand Ms. Kathleen Frawley is on her way, so we are going to wait another minute or two for her, but thank you for being here.

We will take a short recess.

[Brief recess.]

Mr. WAXMAN. The meeting will come to order.

To complete our testimony on the issues of civil and privacy rights protections in the President's proposal, we have with us Ms. Kathleen Frawley, director of the Washington Office of the American Health Information Management Association.

Ms. Frawley, we are pleased you are here and your prepared statement will be in the record in full.

We would like to ask, if you would, to limit the oral presentation to no more than 5 minutes.

STATEMENT OF KATHLEEN A. FRAWLEY

Ms. FRAWLEY. Thank you, Mr. Chairman.

Thank you very much for the opportunity to appear before the subcommittee to present AHIMA's views on confidentiality and privacy, and particularly the need for Federal legislation.

The American Health Information Management Association represents 35,000 credentialed professionals who are responsible for managing the health care information which has become an increasingly important component of our Nation's health care delivery system.

On a daily basis, health information management professionals ensure that an individual's right to privacy is protected. Our members must handle requests for health information from third-party payers, employers, researchers, attorneys, other health care providers, local, State and Federal agencies.

Health information management professionals ensure that information is disclosed pursuant to valid authorizations from the patient or their legal representative or pursuant to statute, regulation or court order. This responsibility is not taken lightly and is complicated by lack of uniform national guidelines or legislation.

The recently released Office of Technology Assessment report, "Protecting Privacy in Computerized Medical Information", found that current laws do not in general provide consistent comprehensive protection of health information. Focusing on the impact of computer technology, the report concluded that computerization reduces some concerns about privacy of health information, while increasing others. The report highlights the need for enactment of a comprehensive Federal privacy law.

The public's concern about the confidentiality of health information was identified in a poll conducted last summer by Louis Harris and Associates, for Equifax, Incorporated. The results of this survey were released at a conference sponsored by the American Health Information Management Association and Equifax in conjunction with the U.S. Office of Consumers Affairs.

The survey found that a large majority of Americans, 89 percent, believe that reforming health care is one of the top domestic issues facing the Nation today. Fifty-six percent indicated strong support for comprehensive Federal legislation to protect the privacy of medical records as part of health care reform.

There was high agreement on what should be included in national privacy legislation. Ninety-six percent of those surveyed believe Federal legislation should designate all personal medical information as sensitive and impose severe penalties for unauthorized disclosure. Ninety-five percent favor legislation that addresses individual's rights to access their medical records and creating procedures for updating or correcting those records.

Currently, there is little uniformity among State licensure laws and regulations regarding confidentiality of health information. It has been recognized that there is a need for more uniformity among the 50 States.

The development of the national information infrastructure is a key component of the President's Health Care Reform Plan. Efforts to reform this health care delivery system will rely heavily on administrative simplification and computerization of health informa-

tion to control costs, improve quality of care and increase efficiency. The increasing need for data highlights the need for Federal preemptive legislation to protect the confidentiality of health information.

In the administration's Health Security Act, privacy of personal health information is addressed. The National Health Board would be established to develop and implement a health information system. Within 2 years of the enactment of this act, the National Health Board would be responsible for the development of privacy and security standards to address unauthorized disclosure and provide individuals with the right to access their personal health information.

The act requires that, within 3 years of enactment, the board shall submit to the President and Congress a comprehensive legislative proposal, based on a code of fair information practices, to protect the privacy of individually identifiable health information.

Health care reform must address the privacy of personal health information now. Individuals must be assured that the highly sensitive personal information contained in their medical records will be protected from unauthorized disclosure.

During the past 2 years, our association has taken a leadership role in addressing these concerns. In July of 1992, Arthur Ashe was a keynote speaker at our first confidentiality symposium. Mr. Ashe spoke eloquently of his decision to disclose his medical condition and his concerns regarding invasion of privacy. During that conference, both Mr. Ashe and other speakers highlighted the need for Federal legislation to ensure that individuals have access to their health information and also to protect the confidentiality of their health records.

In order to address the need for Federal legislation, the American Health Information Management Association has drafted model legislation language. There are a number of key provisions in AHIMA's model which we believe are essential to govern the collection, use and disclosure of health records.

Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy and in health care, and may affect a patient's ability to obtain employment, education, insurance, credit and other necessities. AHIMA believes that it is critical for legislation to be enacted in the coming year.

Thank you for the opportunity to present our views.

[Testimony resumes on p. 538.]

[The prepared statement of Ms. Frawley follows:]

STATEMENT OF KATHLEEN A. FRAWLEY

Mr. Chairman and Members of the Subcommittee:

My name is Kathleen A. Frawley and I am Director of the Washington, D. C. Office for the American Health Information Management Association (AHIMA). AHIMA appreciates this opportunity to appear before the Subcommittee to present our views on privacy and confidentiality and the need for federal legislation.

The American Health Information Management Association represents 35,000 credentialed professionals who are responsible for managing the health care information which has become an increasingly important component of our nation's health care delivery system.

On a daily basis, health information management professionals ensure that an individual's right to privacy is protected. Our members must handle requests for health information from third party payors, employers, researchers, attorneys, other health care providers, local, state and federal agencies. Health information management professionals ensure that information is disclosed pursuant to valid authorizations from the patient or their legal representative or pursuant to statute, regulation or court order. This responsibility is not taken lightly and is complicated by lack of uniform national guidelines or legislation.

NEED FOR FEDERAL LEGISLATION

The recently released Office of Technology (OTA) report, Protecting Privacy in Computerized Medical Information, found that current laws do not, in general, provide consistent, comprehensive protection of health information confidentiality. Focusing on the impact of computer technology, the report concluded that computerization reduces some concerns about privacy of health information while increasing others. The report highlights the need for enactment of a comprehensive federal privacy law.

The public's concern about the confidentiality of health information was identified in a poll conducted by Louis Harris and Associates for Equifax, Inc. The results of the Health Information Privacy Survey 1993 were released at a conference sponsored by AHIMA and Equifax in conjunction with the U. S. Office of Consumer Affairs on October 26, 1993. Senator Patrick Leahy (D-VT) and Representative Pete Stark (D-CA) and several panelists identified the need to address privacy of health information in any health care reform plan.

The survey found that a large majority of Americans (89%) believe reforming health care is one of the top domestic issues facing the nation today. Fifty-six percent (56%) indicated strong support for comprehensive federal legislation to protect the

privacy of medical records as part of health care reform.

There was high agreement on what should be included in national privacy legislation. Ninety-six percent (96%) believe federal legislation should designate all personal medical information as sensitive and impose severe penalties for unauthorized disclosure. Ninety-five percent (95%) favor legislation that addresses individuals' rights to access their medical records and creating procedures for updating or correcting those records.

Currently, there is little uniformity among state licensure laws and regulations regarding confidentiality of health information. It has been recognized that there is a need for more uniformity among the 50 states. In recent years, the National Conference of Commissioners on Uniform State Laws developed the Uniform Health Care Information Act in an attempt to stimulate uniformity among states on health care information management issues. Presently, only two states, Montana and Washington, have enacted this model legislation. Clearly, efforts must be directed toward developing national standards on privacy and confidentiality.

HEALTH CARE REFORM AND THE NATIONAL INFORMATION INFRASTRUCTURE

The development of the national information infrastructure

is a key component of the President's health care reform plan. Efforts to reform this country's health care delivery system will rely heavily on administrative simplification and computerization of health information to control costs, improve quality of care and increase efficiency. The increasing need for data highlights the need for federal pre-emptive legislation to protect the confidentiality of health information.

In the Administration's Health Security Act (Title V, Subtitle B, Part 2), privacy of personal health information is addressed. The National Health Board would be established to develop and implement a health information system. Within two years of the enactment of this Act, the National Health Board would be responsible for the development of privacy and security standards to address unauthorized disclosure, and provide individuals with the right to access their personal health information. The Act requires that, within three years of enactment, the Board shall submit to the President and Congress a comprehensive legislative proposal, based on a Code of Fair Information Practices, to protect the privacy of individually identifiable health information.

Health care reform must address the privacy of personal health information now. Individuals must be assured that the highly sensitive personal information contained in their medical records will be protected from unauthorized disclosure.

AHIMA'S POSITION

During the past two years, AHIMA has taken a leadership role in addressing privacy and confidentiality. In July 1992, Arthur Ashe was a keynote speaker at AHIMA's first annual confidentiality symposium. Mr. Ashe spoke eloquently of his decision to disclose his medical condition and his concerns regarding invasion of privacy. During that conference, both Mr. Ashe and other speakers highlighted the need for federal legislation to ensure that individuals have access to their health information and to protect the confidentiality of their medical records.

In order to address the need for federal legislation, the American Health Information Management Association (AHIMA) drafted model language in February and March of 1993 with input from AHIMA members, members of the Computer-Based Patient Record Institute Workgroup on Confidentiality, Privacy and Legislation and individuals from other professional associations.

This model language was presented to members of The White House Task Force on Healthcare Reform on April 29, 1993. The model language was also included in the OTA report.

There are a number of key provisions in AHIMA's model language which we believe are essential elements of any legisla-

tion to govern the collection, use and disclosure of health care records. These include:

- ▼ **Disclosure** -- No person other than the patient or the patient's representative may disclose health care information to any other person without the patient's authorization, except as authorized in this act.

No person may disclose health care information under a patient's authorization, except in accordance with the terms of such authorization.

The provisions of this section apply both to disclosures of health care information and to redisclosures of health care information by a person to whom health care information is disclosed.

- ▼ **Record of Disclosure** -- Each person maintaining health care information shall maintain a record of all external disclosures of health care information made by such person concerning each patient, and such record shall become part of the health care information concerning each patient. The record of each disclosure shall include the name, address and institutional affiliation, if any, of the person to whom the health care information is disclosed, the date and purpose of the

disclosure and, to the extent practicable, a description of the information disclosed.

▼ **Patient's Authorization; Requirements for Validity --**

To be valid, a patient's authorization must --

- 1) Identify the patient;
- 2) Generally describe the health care information to be disclosed;
- 3) Identify the person to whom the health care information is to be disclosed;
- 4) Describe the purpose of this disclosure;
- 5) Limit the length of time the patient's authorization will remain valid;
- 6) Be given by one of the following means --
 - a) In writing, dated and signed by the patient or the patient's representative; or
 - b) In electronic form, dated and authenticated by the patient or the patient's representative using a unique identifier.

The AHIMA model also includes the following principles of fair information practices:

- ▼ **Patient's right to know --** The patient or the patient's representative has the right to know that health care

information concerning the patient is maintained by any person and to know for what purpose the health care information is used.

- ▼ **Restrictions on collection** -- Health care information concerning a patient must be collected only to the extent necessary to carry out the legitimate purpose for which the information is collected.
- ▼ **Collection and use only for lawful purpose** -- Health care information must be collected and used only for a necessary and lawful purpose.
- ▼ **Notification to patient** -- Each person maintaining health care information must prepare a formal, written statement of the fair information practices observed by such person. Each patient who provides health care information directly to a person maintaining health care information should receive a copy of the statement of a person's fair information practices and should receive an explanation of such fair information practices upon request.
- ▼ **Restriction on use for other purposes** -- Health care information may not be used for any purpose beyond the purpose for which the health care information is col-

lected, except as otherwise provided in this [ACT].

- ▼ **Right to access** -- The patient or the patient's representative may have access to health care information concerning the patient, has the right to have a copy of such health care information made after payment of a reasonable charge, and, further, has the right to have a notation made with or in such health care information of any amendment or correction of such health care information requested by the patient or patient representative.

- ▼ **Required safeguards** -- Any person maintaining, using or disseminating health care information shall implement reasonable safeguards for the security of the health care information and its storage, processing and transmission, whether in electronic or other form.

- ▼ **Additional protections** -- Methods to ensure the accuracy, reliability, relevance, completeness and timeliness of the health care information should be instituted. If advisable, additional safeguards for highly sensitive health care information should be provided.

The AHIMA model language also contains provisions for civil and criminal penalties to protect against unauthorized use or

disclosure.

CONCLUSION

Health care information is personal and sensitive information, that if improperly used or released, may do significant harm to a patient's interests in privacy and in health care, and may affect a patient's ability to obtain employment, education, insurance, credit, and other necessities. Persons maintaining health care information need clear and certain rules for the disclosure of health care information. The movement of patients and their health care information across state lines, access to and exchange of health care information from automated data banks and networks, and the emergence of multi-state providers and payors creates a compelling need for federal law governing the use and disclosure of health care information.

AHIMA believes that it is critical for legislation to be enacted in the coming year. Thank you for the opportunity to present our views. We look forward to working with the Subcommittee on this issue.

Mr. WAXMAN. Thank you very much, Ms. Frawley.

In your testimony you describe a broad range of confidentiality protections that should be included in the Health Security Act. One of the stumbling blocks that many people had in confidentiality issues arises from family coverage. For example, should a wife have access to her husband's mental health records or should a husband have access to his wife's substance abuse records or should parents have access to their teenager's STD results? How would you suggest we resolve these questions?

Ms. FRAWLEY. Right now there is a variety of approaches that many of the States have taken on these different issues, and in the interest of public health reporting purposes, some of the States have felt that it would be prudent to encourage people who seek treatment to ensure that information is highly protected. And even though it might involve a minor, say, seeking treatment for sexually transmitted diseases, to encourage treatment, there have been protections built into place that information cannot be disclosed without that minor's authorization.

Our association feels that it is the individual who seeks treatment; it is their right to decide who should have access to their personal health information. So, therefore, we would support the right of any individual to seek treatment and to know that their information is protected from disclosure, even if it is to another family member.

Mr. WAXMAN. I think all States now protect confidentiality of STD records. Absolutely, they do this to encourage more people to volunteer for testing and treatment.

Can such confidentiality conditions exist under a uniform information system?

Ms. FRAWLEY. I think so, and I think the important thing is to make people feel that they can seek treatment. That information will not be disclosed without their authorization. If there is any disclosures pursuant to public health reporting purposes, individuals should have the right to know how their information is going to be collected, how it will be used.

If, for example, there will be a reporting to other agencies or to State databases, individuals need to know that before they enter into the health care delivery system and certainly should have the expectation that their information will be protected.

Mr. WAXMAN. Last week, we heard from the National Council of La Raza, the two elements of the President's bill, the denial to cover undocumented aliens plus the use of a health security card will, in combination, they say, create an enormous threat to the civil rights of all Latinos of the United States, whether they are U.S. citizens or not.

They argue that the bill will create a de facto national ID card for Latinos and Asians regardless of immigration status, a card that those suspected of being foreign will have to carry in order to protect themselves from harassment from law enforcement officials and to identify themselves for simple procedures, like opening bank accounts and obtaining mortgages.

Do you agree that the use of the Health Security Card in the President's bill will lead to discrimination against Hispanic- and

Asian-Americans, and do you have any suggestions about how we might reduce the possibility of such a result?

Ms. FRAWLEY. We are very concerned about the Health Security Card being used as a de facto national identification card. There have been a lot of studies that have indicated that there is significant cost associated with the use and development of a National Health Security Card.

Our association is committed to administrative simplification in the health care delivery system and would suggest that we really need to evaluate whether we need a Health Security Card, and if it is determined that there is an appropriate use for one, that it really be limited to just verification of eligibility for the purposes of accessing the health care delivery system. It certainly should not become a "smart card" and contain clinical information that is not protected and certainly should not be used to discriminate against anyone on the basis of their ethnic or immigration status as far as seeking health care in this country.

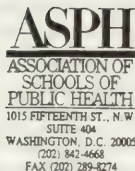
Mr. WAXMAN. Well, I thank you very much for your testimony, both your oral and your written testimony and your response to these questions.

Ms. FRAWLEY. Thank you for the opportunity to testify. We look forward to working with you.

Mr. WAXMAN. That concludes our hearing for today. We stand adjourned.

[Whereupon, at 12:50 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted:]



**STATEMENT OF THE
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH**

**TO THE COMMITTEE ON ENERGY AND COMMERCE SUBCOMMITTEE
ON HEALTH AND THE ENVIRONMENT ON HEALTH CARE REFORM**

**February 4, 1994
Washington, D.C.**

The Association of Schools of Public Health (ASPH*) is grateful for the opportunity to testify on our association's views on health care reform. Public health is the underlying concept for any effective health system. **Population-based disease prevention/health promotion, which is synonymous with public health, must be the cornerstone of the health care reform initiative.** A health care system that assures access to health care for all persons cannot succeed in building a healthier America unless it addresses disease prevention and health promotion in a comprehensive fashion. Population-based measures extend beyond the boundaries of any individual health provider or facility.

As such, the Association of Schools of Public Health is on record in support of President Clinton's health care reform plan (H.R. 3600). It strongly supports the public health, preventive medicine and prevention research provisions of the plan, as well as its overall principles. ASPH applauds the President's vision and resolve in proposing a national health care plan and for making it a central theme of his presidency.

However, as experts in the public health professions education field, the members believe that all health care reform proposals should place more emphasis on relieving the serious shortage of comprehensively-trained professionals needed to meet health care reform objectives, especially those trained to deal with previously neglected or unidentified morbidities: HIV/AIDS, drugs, alcohol, violence, tobacco, depression, among others.

The importance of this issue was clearly outlined in the **HHS Secretary's Eighth Report on Health Personnel to Congress** in 1991. HHS listed personnel shortages in several public health occupations and stated that the problem is exacerbated by a lack of training in basic public health principles and contemporary methods. Many state/local health department directors have reported that the lack of practical knowledge and skills in the core sciences of public health and preventive medicine has restricted the effectiveness of their agencies. In order to improve the quality of the American public health infrastructure, and therefore, to properly set the stage for health care reform and prevention, we must provide adequate training, education and continuing education to the public health workforce.

Many national health groups--especially the maternal and child health agencies and state/local health officials--agree that regional shortages of adequately trained professionals

* ASPH is the only national organization representing the deans, over 2,200 faculty and over 13,000 students of the 26 schools of public health. The schools represent the primary education system that trains personnel needed to operate our nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel. It was formed in 1959 in response to the need to give a national voice to academic public health. A list of the 26 accredited schools of public health is attached.

present the most significant barrier to providing population-based prevention initiatives, in general and ensuring the delivery of quality health care to underserved individuals and underrepresented populations, in particular. Health professionals trained to handle the unique demands of rural and inner-city public health issues are in the shortest supply.

In order to meet the national health goals adopted as part of Healthy People 2000, as well as objectives of the President's health care reform plan, we need an adequate supply of well-trained and qualified health professionals, including public health physicians. We urge Congress to recognize that, under health care reform, the public health system would be responsible for community assessment of needed services, assurance that groups of providers are available to meet community needs, and administration of programs which promote disease prevention, healthy lifestyles and a safe environment. In addition, we encourage recognition that public health professionals will be needed to ensure the provision of necessary services not provided by other components of the proposed health care system (e.g., services to underserved populations in rural and inner city areas, including the elderly, disabled, teenaged mothers and their infants, the homeless and undocumented workers, among others).

Lasting reform of our health care system requires a strategic (long-term) commitment to training public health personnel, shoring-up the public health infrastructure and the prevention research enterprise. But filling the current occupational voids and ensuring a supply into the next century is a priority both nationally and regionally. Therefore, ASPH recommends the following provisions to health care reform proposals be sustained or included:

- Recognition of the complementary role of community-based public health measures in health care reform; there is a need to mandate the integration of public health with medical care through community-based "networks and plans"
- Recognition that a critical mass of the basic public health disciplines of epidemiology, biostatistics, environmental health, health services administration, behavioral and social sciences, among others, is needed to build a prevention research capacity and to re-build the current public health infrastructure, as well as to manage health care reform plans.
- Three percent (3%) of national health care expenditures should be set aside to support the core functions of public health including the education of the public health workforce and health professionals to accomplish these core functions. We believe that it is crucial to provide for a guaranteed, predictable and consistent source of support for core public health functions.
- Consolidation of current federal academic public health support programs into a new authorization that would earmark \$50 million to train future public health professionals (a **Public Health Service Corps**) through accredited graduate public health educational programs to usher in health care reform at the federal, state and local level. Under this plan, schools of public health and accredited programs in preventive medicine, would train and educate a cadre of new public health professionals, with special skills and competencies needed to function in

a health care reform environment, for careers in official public health agencies and organizations.

Expertise to provide public health services makes increased education of the existing and future public health workforce, in such disciplines as organizational management, cultural sensitivity, interdisciplinary cooperation, biostatistics and epidemiology, planning and program evaluation, and financial management, to name a few, critical to the success of health care reform.

One final recommendation, Mr. Chairman. We respectfully urge that the medical specialty of preventive medicine be included in the definition of primary care in all bills. Schools of public health pay an essential role in training physicians in public health and in the specialty of preventive medicine. They sponsor about 20 percent of all residency programs in preventive medicine, public health, and occupational medicine, and provide academic training to many more public health and preventive medicine physicians. These physicians play important roles in many health care settings where expertise in both clinical medicine and the population-based approach of public health is required. Every major study of national health workforce needs has concluded that there is a shortage of physicians trained in preventive medicine. The Third Report of the Council on Graduate Medical Education (COGME) recommended, as a national goal, increasing the percentage of physicians trained and certified in preventive medicine. We support the President's proposal and others that will enable graduate medical education funding for physicians training in settings other than hospitals. We are alarmed, however, by the proposals's exclusion of preventive medicine from the list of specialties for which training slots will be increased. If preventive medicine must compete with medical subspecialties in oversupply for a reduced number of funded training slots, we fear for its future. We urge the Committee to continue the precedent it set in OBRA 93 by treating preventive medicine the same as the primary care specialties for purposes of graduate medical education funding.

Deans of the U.S. Schools of Public Health recognize that the will to propose a plan to revitalize the health care system was lacking, until now. ASPH also recognizes that population-based approaches to disease prevention and health promotion were not given the benefit of their achievements in lowering the burden of disease and disability, not to mention delaying morbidity, until now. And ASPH recognizes that there is an opportunity now to make a major contribution to our society by reforming the current health care system and adopt a plan that calls for re-building of our nation's public health system (currently "in dissaray"), a plan that calls for the reduction in the burden of controllable health problems, a plan that calls for the education of comprehensively-trained public health professionals to function in a health care reform environment and a plan that calls for population-based approaches in health care reform through the application traditional public health principles and programs: assessment, policy development and assurance.

ASPH appreciates the opportunity to testify on the need for health care reform, in general and for the opportunity to present its views on the need for professionals with population-based expertise to accomplish its goals, in particular.

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TESTIMONY REGARDING "HEALTH CARE OPTIONS" PRESENTATION IN MEDICAL

I. INTRODUCTION

The National Health Law Program, the Legal Aid Society of San Diego, the Legal Aid Foundation of Los Angeles, and the Children's Advocacy Institute, are submitting testimony on behalf of low-income Medi-Cal recipients to raise criticisms regarding the California state Medicaid agency's use of marketing presentations at state welfare offices which are intended to "encourage" Medi-Cal recipients to join managed care plans. Unfortunately, these presentations are biased, misleading, and have been accompanied by high-pressure tactics on the part of eligibility workers and presenters. While the state plans to use such presentations eventually as an alternative to door-to-door marketing by the plans, the result has been to replace one set of deceptive and misleading marketing practices with another.

One of the major problems for consumers with managed care is that consumers often do not know how to use such plans to access timely care. They need education and assistance in both determining whether managed care is appropriate for them and if they enroll, in learning how to use such plans. These presentations completely fail to meet this need.

The problems with these presentations should prove instructive as legislators consider designing consumer protections which will enable consumers to make meaningful choices concerning enrollment in health plans.

II. BACKGROUND TO THE REVISED HEALTH CARE OPTIONS PRESENTATION

In an effort to curb the rampant marketing abuses associated with door-to-door marketing by managed care plans, as well as fraudulent and abusive marketing practices at hospitals, food stamp centers, and WIC offices, the California Legislature has called for the elimination of door-to-door marketing by next summer. To replace door-to-door marketing, the Department of Health Services (DHS) plans to use Health Care Options (HCO) presentations at local welfare offices.

DHS already had been using such presentations, but beginning in September 1993, DHS revised these presentations to "encourage" the use of managed care. These revised presentations were piloted in welfare offices in Los Angeles and Contra Costa Counties.

These revised presentations are also the first step in the state's process to institute "default," a program under which Medi-Cal recipients who fail to certify that they have a relationship with a fee-for-service provider can be enrolled automatically in a health plan. See Calif. Welf. & Inst. Code § 14016.5(c)(1). However, HCFA specifically has requested that DHS delay its implementation of default until HCFA has given approval to the presentations, in order to "ensure HCO presentations are objective and fairly represent both managed care and fee-for-service (FFS) options."

III. THE REVISED HCO PRESENTATIONS ARE FRAUGHT WITH PROBLEMS

The substitution of the revised Health Care Options

presentations is perpetrating yet another set of misleading, unfair, and dangerous marketing practices. In fact, legal services offices have filed a lawsuit challenging the state's authority to do such presentations under federal and state law. See Lenore M. v. Belshe, No. BC093821, L.A. County Superior Court (Nov. 23, 1993).¹

The revised presentations are biased in the following ways. First, they claim that managed care offers "extra" benefits and that fee-for-service Medi-Cal offers only "basic" services. This statement creates a misimpression that managed care offers extra medical benefits not available under fee-for-service. This is an untrue statement. Medi-Cal recipients are entitled to the same scope of services inside as well as outside of managed care plans. Second, these presentations indicate that an advantage in managed care is that there are no copayments for emergency care. This is extremely misleading in that in fee-for-service care, copayments are charged only if the recipient uses emergency care for a non-emergency. Under managed care, the recipient can be held liable for the payment by the hospital for using emergency

¹ The lawsuit raises federal freedom of choice claims based on the fact that the presentation is not complete and objective, and recipients are being instructed that they must attend presentations when, in fact, enrollment in managed care still is voluntary. The lawsuit raises state law claims based on state law requirements that the presentations must be complete and objective and must explain "the benefits and limitations" of both managed care and fee-for-service care (Calif. Welf. & Inst. Code § 14016.6(b)) and that beneficiaries and applicants must be "assured" the right to "make a well-informed choice, without duress." Id. at §14016.6(c).

care in a non-emergency. Thus, in this respect, recipients are worse off with managed care.

The presentations also fail to be complete. Recipients are presented with a list of the managed care options, providing addresses of managed care providers, and indicating which providers offer "extra benefits" such as transportation or child care. However, no parallel list of fee-for-service providers is available. Recipients, thus, for example, are not informed of clinics available to them around the corner, or of the extra benefits provided by some clinics, such as transportation and child care, and in addition, translation services, services for the entire family, regardless of Medi-Cal eligibility, or extra social and counseling services, such as special assistance to homeless families provided by some clinics, or special counseling for HIV-related conditions.

In addition, recipients and applicants in the piloted areas are being subjected to high-pressure tactics by the eligibility workers as well as the presenters, just the sort of tactics these presentations were intended to supplant. For example, recipients and applicants have complained of the following: a) being told they must attend presentations; b) being told that they must enroll in a managed care plan; and c) being told that they must enroll in a managed care plan before leaving the presentation. In addition, referral forms being used by the eligibility workers indicate that attendance at presentations is mandatory, which is untrue since enrollment still is voluntary, and forms used at the

presentations are confusing in providing a place for signature which would cut off the applicant's right to use fee-for-service care, regardless of whether the applicant was enrolling in a specific plan.

The danger is that recipients will enroll in managed care plans that they do not understand how to use, or cannot use because of distance or language barriers, or would be inappropriate to meet their specialized health care needs. Managed care plans often involve layers of bureaucracy which are intended to limit inappropriate use. However, for an uneducated consumer, or a consumer inexperienced with such systems, the bureaucracy can create dangerous delays in their ability to access necessary care.

IV. RECIPIENTS ARE BEING DEPRIVED OF THEIR RIGHT TO MAKE MEANINGFUL CHOICES

Even if managed care were the only option, these presentations are antithetical to consumers' ability to make meaningful choices. For example, after the presentations, recipients are not provided any written information about the plans to help them make thoughtful decisions about their choices, they are not given an opportunity to determine if providers they would like to see are part of the plans, and they are not provided any further education to help them learn how to use managed care plans and assert their rights within them if necessary.

V. THE NECESSITY FOR CONSUMER PROTECTION

Because consumers need to be protected against fraudulent

and deceptive marketing abuses, we believe it is a good idea to eliminate door-to-door marketing and to require availability of objective and complete presentations regarding health care options, including fee-for-service options if available. However, the above problems in California should provide an example of how not to do such presentations. The following are suggestions for developing meaningful consumer protections in this area:

1. The presentations truly must be objective.
2. The presentations should provide complete and comprehensive information, including a listing of providers available through each plan, broken down by specialty and location.
3. There should be no coercion or pressure regarding attendance at the presentations.
4. The time-frame within which to make a choice and to change one's mind should be adequate (we suggest a minimum of thirty days).
5. Objective written materials that applicants can take home to study should be available, and should be available in languages other than English for non-English speakers.
6. Counselors should be available to answer questions after the presentations are made, both by toll-free telephone, or in person, including questions about whether specific providers are available in certain plans.
7. Presentations should be available to maximize consumer access to information, including during after-work hours, and at sites other than the welfare offices, such as WIC sites.
8. Consumer education should be available on an on-going basis to provide guidance on how to use such plans, and how to assert rights within plans if necessary.

HEALTH CARE REFORM

Alternative Legislative Approaches

TUESDAY FEBRUARY 1, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:37 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Since last September, this subcommittee has held 19 hearings on President Clinton's health reform plan, H.R. 3600. We have heard over 100 hours of testimony from administration and other witnesses on the structure and financing of the President's plan. Today and tomorrow we will turn our attention to several other bills that propose alternative approaches to health reform.

This morning we will hear testimony on H.R. 1200—the American Health Security Act—which was introduced by our colleague, Congressman McDermott, and which is cosponsored by a number of members of this committee.

This afternoon we will receive testimony on H.R. 3080—the Affordable Health Care Now Act—introduced by the Minority leader of the House, Mr. Michel, and also cosponsored by a number of members of this committee.

As we examine these bills, it is my hope that we will judge each of them by a common set of standards:

First, does the plan guarantee universal coverage for a defined package of comprehensive benefits?

Second, does the plan specify a credible and fair financing scheme to make sure benefits will be provided?

Third, does the plan assure that the costs of coverage are affordable for all families and employers and that the quality of care meets the highest standards?

And, finally, does the plan give all Americans a meaningful choice of their physician and hospital providers?

Unless all of the answers to all of these questions is yes, I don't see how any bill can achieve our health reform goals.

As my colleagues know, I have supported a number of health reform measures over the years. Each of them was based on the principle of guaranteed, comprehensive coverage for all Americans. While there are obviously a number of ways to get to this goal, we must resist the temptation to take easy half-steps toward reform

that leave millions uncovered and exacerbate our health crisis. We are all at risk if we cannot agree on a comprehensive health reform plan.

Before calling on our witnesses, I want to recognize the distinguished Ranking Republican Member of the subcommittee, Mr. Bliley, for his opening statement, and, without objection, all the Members' opening statements will be included in the record at this point.

Mr. BLILEY. Thank you, Mr. Chairman.

During the past several weeks, two of the leading Members of the Senate, Minority Leader Bob Dole and the Senate Finance Committee Chairman, Daniel Patrick Moynihan, have come to a rare meeting of the minds on the state of the American health care system. Both agree that while health care is a very important problem for a lot of people, the American health care system is not in crisis. Senator Moynihan specifically stated that there is not a health care crisis in cost and that the constant administration talk of a health care crisis is not helping the public understanding of the state of the American health care system. Recent economic data show the smallest growth in health care expenditures during the past decade, and public opinion polls regularly show that 9 out of 10 Americans are satisfied with the health care they receive.

Although there is not a crisis in the American health care system, there are significant problems which must be fixed. For the past 2 years the Republican Health Care Task Force has been meeting to hammer out a bill, H.R. 3080, the Affordable Health Care Act of 1993, which provides targeted fixes for specific problems, problems such as job lock, continuity of coverage and pre-existing condition limitations which the President himself identified in his State of the Union address. Later today, the distinguished Minority Leader Bob Michel will testify before this subcommittee on this bill. Accompanying the Leader will be our colleague, Congressman Hastert, and the Ranking Republican on the Ways and Means Health Subcommittee, Congressman Bill Thomas.

I would like to discuss some of the key provisions of the bill.

To increase availability and continuity of health care coverage for employees, the bill does the following:

Requires all employers to offer to employees at least one health care plan;

Encourages employers to facilitate enrollment in health plans through multiple employer purchasing arrangements;

Limits preexisting condition restrictions under all employer health benefit plans;

Ends job-lock by assuring continuous availability of health coverage by prohibiting preexisting condition restrictions;

Prohibits employer health plans from being canceled or denied renewability.

The bill also provides tax fairness for the self-employed and uninsured individuals by gradually increasing the tax deduction for the cost of health insurance premiums for the self-employed from 25 percent to 100 percent.

To expand the capacity of communities to meet the health care needs of low-income and uninsured individuals, the current author-

ization of community and migrant health centers is increased by 1.5 billion over 5 years.

Under this bill, States would be given new flexibility to manage their Medicaid programs more efficiently and to redirect Medicaid disproportionate share funds.

First, States would be allowed to enroll Medicaid beneficiaries in HMO's and PPO's without having to submit cumbersome waiver applications. States would be given the option to mandatorily enroll Medicaid beneficiaries, provided they meet Federal quality assurance standards.

Second, States would be allowed to redirect their Medicaid hospital disproportionate share funds. As the Washington Post again pointed out yesterday, these funds grew from less than a billion dollars in 1989 to approximately \$17 billion today because of a change in law during 1990. Instead of using this money to balance State budgets and build new sports stadiums, States would be allowed to redirect these Medicaid funds into health alliance programs where eligible individuals would be able to enroll in private-market health plans.

Let me conclude with some observations about the upcoming debate. First, the President's threatened veto of any bill that does not immediately offer universal coverage through a nationalized system is uncalled for. Rather than have responsible attempts to establish bipartisan reform which will fix the problems in the insurance market that the President himself identified in his speech, he would rather hold out for a nationalized, command and control, one-size-fits-all health care system which relies on rationing care and limiting individual choice. The only two bills which meet these criteria are his Health Security Act and the McDermott Canadian single-payer bill. As we know, our Canadian neighbors had to shut down their hospitals for 3 weeks during Christmas because the government ran out of money.

We hope in the coming weeks to work with Members from both parties on a health care reform proposal which will build on the strengths of the current system, which is the finest in the world, and fix only those problems that need to be fixed. If the President and the Democrats want to ration health care, limit patient choice, create new payroll and individual taxes and turn the American health care system into a second rate one, they will not do so without a fight from this side of the aisle.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

We started this hearing earlier because some of these witnesses have to leave, but if members of the subcommittee want to give an oral opening statement we will do it later at a later time.

Mr. HASTERT.

Mr. HASTERT. Thank you, Mr. Chairman.

I just want to welcome the distinguished Chairman of Government Operations and my good colleague from Washington, Jim McDermott, whom I have debated from time to time on these issues. I had the honor to travel to Canada with both these gentleman and look at the Canadian system. Perhaps we came to different conclusions, but I look forward to your testimony and certainly your contribution to the ongoing debate.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Hastert.

Mr. Brown.

Mr. BROWN. Mr. Chairman, thank you.

I look forward after particularly hearing talk about—hearing all the myths about Canadian health care and all the horror stories that we have heard over and over again from the media, from members of this committee, from the insurance industry, from opponents of single payer.

I look forward to hearing what is really going on in Canada, and I cite one interesting poll that appeared some months ago in Harper's magazine that twice as many Canadians—this was actually a poll taken in Canada—twice as many Canadians believe Elvis Presley is still alive than the number who prefer the American health care system over the Canadian health care system. And that is—that may tell you something about the public support of single payer in Canada and tell us as lawmakers in this country why we should look much more seriously at the Canadian plan.

Mr. WAXMAN. Thank you, Mr. Brown.

We are pleased to welcome for our first panel the author and two of the 91 cosponsors of H.R. 1200, the American Health Security Act, the Honorable Jim McDermott of Washington, who introduced the bill; the Honorable John Conyers of Michigan, the distinguished chair of the House Committee on Government Operations; and the Honorable Nancy Pelosi of California, a leader in the fight to assure access to care with people with AIDS and on behalf of women's health.

I want to welcome each of you to our subcommittee hearing today. Your written testimony without objection will be in our record in full. We would like to ask you, if you would, to keep to a 5-minute time frame for the oral presentation.

Mr. McDermott.

STATEMENT OF HON. JIM McDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. McDERMOTT. Thank you, Mr. Chairman and members of the subcommittee.

I am here today as the one of the coauthors of the American Health Security Act, and I want to thank the subcommittee for taking the time to hear testimony on this legislation.

This subcommittee and the Congress are beginning a historic debate on national health care reform. It is long overdue, and I know that many Members, including the chairman, have been involved in this very deeply for a very long time. The Washington Post gave this subcommittee chairman great credit for his efforts, and I think that this is not a new debate for many of you.

President Clinton also deserves credit for placing the health care reform issue first on the agenda for the Nation. It is now time for Congress to respond to the challenges before us.

Now, we are all aware of the need for reform of the Nation's system of providing and paying for health care. I am not going to waste your time convincing you of the existence of a health care crisis. The American people know the indisputable reality of this

crisis, and, as far as I am concerned, anyone who tries to convince them otherwise can just defend that at the polls.

This morning in the Washington Post, both Mr. Dole and Mr. Moynihan retracted their statements about there being no health care crisis.

The time has come, really, to start making decisions. So far, the debate has focused on competing slogans, but we all know that slogans are not going to be enough to get us through this issue because every citizen will be personally affected by this vote, and if we misled them, every voter will know it in very short order.

Yogi Berra said, when you come to the fork in the road, take it. And we are at a fork. We can consolidate the control of insurance companies over our health care delivery system and spend all our resources policing how they do the job or we can give the control to the American people.

H.R. 1200 gives you the chance to vote for something that will cost your constituents less and give them more than they have ever had, and you will be able to explain to them—easily and clearly—exactly how it will work.

I believe that is a vote you can defend. Every other option, including the status quo, will cost the American people much more and give them much less. They may not be able to understand that today, but they will figure it out in a very short time, and they will hold those of us who failed to seize the opportunity for the best accountable for that decision.

So let's talk reality and substance and bottom lines.

I am here today to discuss a proposal which at least 93 other Members of Congress feel is the most cost-effective approach to preserving the best aspects of our current system, while taking bold and necessary steps to correct the inequities and shortcomings of our current system of financing health care.

In short, H.R. 1200 offers the best approach to health care reform because it is simple and universal. It is proven, and it is efficient. H.R. 1200 is an American single-payer model of health care financing which guarantees universal coverage while preserving the best aspects of the private delivery system.

This is in sharp contrast to other proposals before the Congress. President Clinton's plan aspires to universal coverage, but it will not achieve this except through a major disruption of the current system which has never been tested before. Other proposals before the Congress do not even pretend to achieve universal coverage.

More significantly, H.R. 1200 accomplishes the goals of universal coverage, the preservation of the current private physician-patient relationship and offers the most comprehensive benefit package while accruing the largest savings compared to any other proposal.

We are going to get into a battle of words and phrases and slogans, but the Congressional Budget Office says the single-payer approach will save up to \$175 billion a year from the Nation's health care bill by the year 2003. Up to \$100 billion will be saved in administrative savings alone. This is compared to only an estimated \$7 billion savings in administrative cost in the President's bill. That is from Ira Magaziner directly.

I am proud to be the sponsor of the only proposal for health care reform that is fully financed and that guarantees universal cov-

erage which are requirements that a number of polls have said as high as 78 percent of the American people demand be part of reform. There is no smoke and mirrors, no phoney numbers. And, unlike Mr. Cooper's proposal and Mr. Chafee's proposal, there is no hidden income tax penalties for most middle Americans in addition to the health insurance and out-of-pocket costs that they will pay.

Indeed, I want to commend the cosponsors of Mr. Cooper's bill for their political courage in supporting income tax increases without offering defined benefits or coverage in return. There are 19 Republicans who do this. It really intrigues me. I would like to hear them explain the defense of an income tax increase.

Under H.R. 1200, every American will know exactly how much health insurance is going to cost in the foreseeable future, and 75 percent of Americans will pay less in 1999 than they are paying today for their health insurance.

Seventy-five percent will pay less for a benefit package that is the most comprehensive, including home, community-based and nursing home long-term care, prescription drugs, comprehensive mental health and substance abuse services, as well as a full array of preventive and acute care services.

Seventy-five percent will pay less for a plan that gives them unrestricted choice of provider, not just choice of plan. And there is a real distinction. We give them free choice of provider.

Seventy-five percent will pay less for a plan which eliminates interference in the doctor-patient relationship by prohibiting recertification of medical decisions by some accountant on a 1-800 number. Seventy-five percent will pay less for a plan that eliminates for consumers the need to file reams of paper with insurers and dramatically reduces the administrative burden.

H.R. 1200's numbers are the cleanest numbers in town. The bill was scored by CBO, and the numbers were sent to the Joint Tax Committee to raise the required revenue. Period. We have a \$9 billion surplus by year three, and universal coverage in year one. Our payroll deductions for a public health insurance premium for most small businesses and individuals are smaller than the President's plan and definitely less than most businesses and individuals are paying for insurance today.

Now, no one else can tell the American people what their proposal will cost Americans individually for one major reason: No one else can tell the American people what their private health insurance premiums are going to cost, and no other proposal can verify whether or not those premiums are going to be affordable.

Let's get one thing straight. Universal coverage is affordable. The reason our numbers are the best in town—and always will be—is because the administrative savings by eliminating the insurance company middlemen more than pay for the universal coverage. No mistake about it. The tortured, cumbersome and, in my opinion, futile attempt to keep insurance companies in the mix is consuming our resources for universal coverage.

How many of you have a district where they love insurance companies? I would like to go out there.

The Consumers Union found that our bill is the best for all segments of the population, especially for children and senior citizens. The American Medical Women's Association endorses our bill as

the best for women. The Public Health Association endorsed our bill as the best reform for the public health infrastructure of this country.

The American people are not looking for a political patchwork on the system again. We have done it again and again and again and again. They are looking for a health care system that is simple to understand, with clear guarantees of coverage and affordability. H.R. 1200 is the only proposal that does that. When you take it home to your constituents, they will know you have done good work for them.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. McDermott.

Mr. Conyers.

STATEMENT OF HON. JOHN CONYERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CONYERS. I wanted to commend Dr. McDermott for a great presentation. And I also want to be very, very proud of your work, Mr. Chairman, and my colleague, Denny Hastert, and Government Operations. And here in the health care field, your name is being mentioned all over town as the man in motion on this, and I am pleased to be before your committee today.

And I am so proud to be a part of this American legislative history about how to deal with a problem that has been bugging us since 1934 when Franklin Roosevelt took a look at it and was talked out of it. And it came together.

We were working with Marty Russo before, but when Dr. McDermott and I and Paul Wellstone began pushing all these papers about, we didn't do it in the political sense. We took a set of principles and organized them and came out with a legislative package: strong consumer role, the patient chooses the doctor, targeted assistance to the medically underserved.

For the first time we are going to take care of the millions of people who have been historically underserved in our country. Free choice of providers that you don't give up anything. No socialism, friends. Everybody chooses their doctor, their hospital, the same way. Fair financing.

And we have had some important changes that the Doctor has introduced into our bill that we hope we will get a chance to talk about: One-tier care, one quality of health care for everybody in the country. Not just because it is the right thing to do, but because it will save us money. In the end it is going to be preventive. Comprehensive benefits where we finally say going to a dentist is part of good health care. Amazing conclusion. That getting your pharmaceutical needs and the prescriptions are part of staying healthy. And then, of course, universal coverage.

So I am really proud of this discussion that we are beginning under your leadership, Mr. Chairman. I am so proud of the fact that we have one 1,627 organizations supporting this bill.

And in my area it came from unions who have a great health care package. The UAW, they pay their employees' premiums. You don't even have to worry about it. They know that the end of line is coming because once negotiated, what drives everybody to a

strike line is diminishing benefits and increasing premiums in every ball. We know it is going to run out.

So I was pleased when Actors Equity, textile workers, the Coalition of Black Trade Unionists, graphic artists, the large and the small, the teachers, all of them looked at this set of principles and said we want to support a bill that supports these principles.

It is not a Democratic bill. It is not a labor bill. And, most of all, it deals with these great groups that are not covered in the health system.

Twenty-two percent of African-Americans uninsured. The gap in life expectancy between white and black is 5 years and growing each year. The infant mortality rate of African-Americans, 2.4 times higher than white infants. We can control that. We can change it. We can make a difference. Inner city black children's immunization rates are 20 percent behind the immunization rates for others.

Health care reform provides a critical opportunity to address these disparities and provides all Americans from birth-to-grave health security. It is in the national interests. It is the right thing to do.

And thank goodness President Clinton raised the issue. The then President said, what health care crisis? And you now finally have had most people sign off of that tired, lame alibi as a reason to not get in this debate. And that is why I coauthored with my good friends, Dr. McDermott and Wellstone, the American Health Security Act.

Eighty percent of my colleagues in the Congressional Black Caucus have all endorsed it and really believe that we now have a system to stand up, advocate, debate and try to have the best thing we can come out of this Congress and go to the President's desk. We are going to do something this year, and this is the height of—in terms of my career, in terms of a social reform program, because I think this health care is an item whose time has come.

Now, universal coverage and universal access is now trying to be interchangeably confused. But you know you can have access to buying a Mercedes, but it doesn't get—it gets you in the door, but it does not get you a deal with the salesman. We are talking about the moral imperative of taking care of a system that can truly contain costs, moving beyond the false security of access. And what we are going to do is deal with it in a date certain by 1997, comprehensive benefits.

The more benefits we include in global containment, the more control we will have over the system. Oh, it is true that costs are going down a little bit now because everybody is looking at it, but it did when other Presidents took a look at this and then, after they failed, the costs kept going up in their regular pattern of ascension.

We offer the most comprehensive benefits package that anybody has, including long-term care, substance abuse, mental health benefits, and I am proud of that. We are speaking to the whole thing, no co-payments or deductibles of acute and preventive services. These charges primarily serve to discourage those who need it most and are costly to administer.

And we have the stamp of approval from a person who could care less about whose principles and who put it together. Bob Reischauer over in the Congressional Budget Office has said that H.R. 1200, our bill, is the most effective at containing costs, that we can save between \$145 billion and \$175 by the year 2003 when the cost containment strategy is fully kicked in. He was hesitant to even venture a guess about managed competition because it is, in truth, an untested theory.

We have a provision for a single-payer plan to come into the States even in the Clinton plan. I want to brag about that because everybody understands that this is the way we really ought to go, and they are making a way for it to happen.

CBO figures we will save at least \$52 billion in paperwork under our bill. GAO studied the Canadian single-payer system and said it would save almost 10 percent of health care spending, \$90 billion a year.

And, by the way, we are not mimicking the Canadian plan. We are taking their principles and applying it to a great system that we have. We know we have the best technical research, advanced studies. Our administrative systems have some things that everybody looks at.

And we are not just going to Canada to take a bill. We are taking those principles, and we are looking at them carefully, and, yes, they have their problems, too. But we are taking an American system and improving it with principles that have worked with the Germans, with the Japanese and the Canadians alike.

One-tier care. There is no reason that a black child in Anacostia should have access to poorer quality care than any other kid in this country. We eliminate the multitiered system, the emergency rooms that—where many people in the cities now are forced to go, the Cadillac plans that exist in some communities, a Medicaid program whose payment rates are 60 percent of the private insurer rates. How can you tell doctors to keep dealing with Medicaid when they can't even break even handling the program? And we wonder what is wrong in our system.

There aren't the high-cost low-cost health plans that are proposed even in the President's bill and others. Such schemes would only formally institutionalize inferior health care and result in racial and socioeconomic redlining. Mr. Chairman, if you were the CEO of a health plan focused on the bottom line, would you locate in Beverly Hills or south central Los Angeles? I even hesitate to raise the question since you are from California.

Free choice of provider, and I want to close now. There is bipartisan support for not restricting patient choice. And, ironically, in this regard the most radical proposals are those based on managed competition. Under our bill the government reforms the health financing system to make it more simple and controllable. Only under managed competition will there be dramatic reform of the delivery system. Single payer provides the wide choice. Managed competition restricts the choice by forcing people to choose between a limited number of health plans, most of which will limit physician choice.

It is out there. If the American people could get these plans all simply broken down to them, there is no question about what they

would want. Whether they were north, south, upper income, middle America, everybody can read and understand that this single-payer system, tested worldwide, improved upon in our plan, is the way that we really ought to go. And I am glad that we are starting off here in this committee with this opening shot on a very, very important subject.

Thank you very much.

Mr. WAXMAN. Thank you, Mr. Conyers, for your excellent statement.

[The prepared statement of Mr. Conyers follows:]

**STATEMENT OF REPRESENTATIVE JOHN CONYERS, JR.
ON H.R. 1200, THE AMERICAN HEALTH SECURITY ACT,
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
FEBRUARY 1, 1993**

Thank you, Chairman Waxman, for holding this hearing on H.R. 1200, the American Health Security Act, and for inviting me to testify. It is clear, Mr. Chairman, that the current health care system needs major surgery, not just a bandaid here or there as some people advocate.

I don't want to take the subcommittee's precious time reviewing the grim health statistics that affect all Americans. I do, however, want to remind committee members that the health crisis disproportionately impacts low-income minorities. Twenty-two percent of African Americans are uninsured, compared to 14.5% of whites. The gap in life expectancy between white and black is five years, and growing each year. The infant mortality rate of African American infants is 2.4 times higher than white infants. Inner city black children's immunization rates lag 20 percent behind immunization rates for other children.

Health care reform provides a critical opportunity to address these disparities and provide all Americans with cradle to grave security. That is why I coauthored, along with my friends Rep. Jim McDermott and Sen. Paul Wellstone, the American Health Security Act. Over 80 percent of my colleagues in the Congressional Black Caucus (CBC) have endorsed H.R. 1200 because we believe it best corrects the current system's underlying problems. Very simply, H.R. 1200 guarantees universal coverage to all Americans through a federally-financed, state administered program. The current health delivery system remains intact, and would still be in the hands of private providers.

Let me review the principles of health care reform that I believe are important to most CBC members and why H.R. 1200 best meets those principles. And let me add that I truly believe they are bipartisan in nature; that they are equally supportable by you Mr. Chairman and by the Ranking Minority member.

Universal Coverage. This principle should no longer be debatable. It's a moral imperative, and it's a practical imperative so that the system can truly contain costs. We must move beyond the false security offered by the guarantee of "universal access" proposed in some health reform proposals. That's the problem today -- everyone has access but too many people can't afford it. H.R. 1200 offers universal coverage by a date certain -- 1997.

Comprehensive Benefits. This is another principle that shouldn't be debatable. If a service is medically necessary, it should be a covered benefit. The more services we cover, the better costs can be contained throughout the system.

H.R. 1200 offers the most comprehensive benefits package of any other bill, including comprehensive long-term care, substance abuse and mental health benefits. By comparison, all other plans only offer skeleton benefits in these three crucial areas. Further, H.R. 1200 requires no copayments and deductibles for acute and preventive services, unlike

other bills. These charges primarily serve to discourage care to those who need it most and are costly to administer.

Cost Containment. Again, no matter what your political stripe, we should all agree that the health care system needs strong and enforceable cost containment. No games. Cost containment must be enforceable today.

The Congressional Budget Office (CBO) rates H.R. 1200 the most effective at containing costs. CBO says H.R. 1200 will save taxpayers between \$145 billion and \$175 billion a year by 2003, when the cost containment strategy gets fully kicked in. CBO is hesitant to even venture a guess about managed competition because it is such an untested theory.

With state single payers, administrative costs under H.R. 1200 will be streamlined, and providers can spend more time providing services rather than pushing paper. That's something liberals and conservatives should both be able to agree on. CBO figures we'll save at least \$52 billion a year on paperwork under H.R. 1200. GAO studied the Canadian single-payer system and said we could save almost 10 percent of health care spending -- \$90 billion a year. No other reform plan can boast of such savings. In fact many of the reform plans may add to the administrative nightmare with complex premium taxes, subsidy schemes, and cost sharing requirements.

Every other major system in the world employs the cost containment tools in H.R. 1200 -- global budgets, negotiated fee schedules, prescription drug prices. If it's good enough for the Japanese and the Germans and the Canadians, who hold health spending to 70 percent or less of our level, why invent a new system that's untried.

One-tier of Care. There's no reason a black child in Anacostia should have access to poorer quality care than the congressman from Alabama. H.R. 1200 eliminates the current multi-tiered system, that ranges from "Cadillac plans" to community clinics. There's no Medicaid program with payment rates at 60 percent of the private insurer rate. There aren't the high-cost and low-cost health plans as proposed in the President's bill, and in others. Such schemes would only formally institutionalize inferior care and result in racial and socioeconomic redlining. Mr. Chairman, if you were the CEO of a health plan focused on the bottom line, would you locate your facility in Beverly Hills or South Central Los Angeles? The answer is Beverly Hills of course.

Free Choice of Provider. Again, I believe there's bipartisan support for not restricting patient choice. Ironically, in this regard the most radical proposals are those based on managed competition. Under H.R. 1200 the government reforms the health financing system to make it more simple and controllable. Only under managed competition will there be dramatic reform of the delivery system. Single payer provides wide choice. Managed competition restricts choice by forcing people to choose between a limited number of health plans, most of which will limit physician choice.

Fair Financing. Any health reform must be paid for, otherwise it shouldn't be taken seriously. It also should be fairly financed. H.R. 1200 does both. With the new financing proposal released just last week businesses would pay between 4 percent and 8.4 percent of payroll, depending on their size and wage scale. Individuals would pay 2.1 percent of payroll and non-payroll income. Seventy-five percent of Americans would pay less than they do now and receive cadillac coverage, with no co-payments or deductibles for most services. Only the President's plan is even close to being in the ballpark of our financing plan -- and at best he's in the bleachers.

Targeted Assistance to the Medically Underserved. There are 35 million medically underserved Americans in inner cities with too few doctors and in rural areas with few doctors and even fewer facilities. Any health reform plan should dramatically increase the supply of primary care physicians, greatly expand the network of low-cost, high-quality health clinics, and provide financial incentives for doctors to practice in underserved areas.

H.R. 1200, like the President's bill, requires medical schools to graduate 50 percent primary care physicians by the turn of the century. H.R. 1200 also doubles funding for community and migrant health centers and doubles funding for the National Health Service Corps to place more physicians in underserved areas. It does so with a guaranteed funding stream -- a fixed percentage of national health spending. Other proposals leave increases to the vagaries of the appropriations process.

Strong Consumer Role. Whatever the health system, consumers must have a prominent role. Under H.R. 1200, consumers sit on the national, state and local boards. Managed care plans under H.R. 1200 must have at least one-third consumer representation. Unfortunately, under managed competition proposals I fear power will be centralized in the hands of insurers operating by the bottom line -- and at the expense of consumers. A recent study found 21 of the 25 fastest growing HMOs were for-profit and the eight biggest insurance companies owned 45 percent of the HMOs in the country. Who else but large, impersonal and profit-driven insurance companies will have the capital needed to establish managed care networks.

Mr. Chairman, the critical condition of our health care system requires that we do major surgery. Without major surgery the patient -- all Americans -- don't have a chance. I believe we can come together in a bipartisan fashion on these principles. And I believe these principles lead us directly to adopting a program like H.R. 1200 that brings all Americans together under the same high-quality insurance policy.

Mr. WAXMAN. Ms. Pelosi.

STATEMENT OF HON. NANCY PELOSI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. PELOSI. Mr. Chairman, thank you very much for the opportunity to testify before this very powerful committee.

I have said it before. The power of this committee is almost Biblical. You can bring good health to people. I know with the efforts Chairman Waxman has made over the years that he has made our country healthier, but unfortunately, we still have a way to go.

I have had the pleasure of working with the distinguished Ranking Member, Mr. Bliley, on the Biotechnology Caucus and commend him for his leadership there and on this committee. And to the other distinguished members of the committee including Dr. Rowland, who has visited our district and listened to our problems, thank you for the opportunity to be here.

I, too, want to say what a privilege it is to join the authors of this legislation on this panel today. Congressman McDermott and Chairman Conyers are to be commended for their leadership.

As Mr. Conyers mentioned, we first offered this legislation when Mr. Russo was carrying the ball. He tossed the ball to these gentlemen. In any case, I would like to associate myself with the remarks of my colleagues.

In my remarks, Mr. Chairman, I would like to focus on the fact that I believe that the Clinton plan and the single-payer plan are the only two plans before the Congress which would provide universal coverage to all Americans. So I will confine my remarks to those two plans because I think they are the only two credible universal coverage plans and are in stark contrast to the other proposals which will be considered.

I believe the President is to be commended for his State of the Union address where he made the parameters for defining what constitutes significant health care reform. We who advocate a single-payer approach hear the President's commitment to enacting legislation which provides health insurance coverage for all Americans by a date certain.

We also are committed to legislation which controls the skyrocketing growth in health care costs. Like the President, we believe that the health care reform legislation must stand the test of Congressional Budget Office scoring for controlling health care costs for the individual and for the government—and that means the taxpayer.

As you know, only two plans now before Congress, the McDermott-Conyers plan and the Clinton plan, either meet or are likely to meet both of these goals.

Our approach, the single-payer approach, is fair. Mr. Chairman, you laid out some parameters at the beginning of your remarks which I believe the single-payer plan meets best. My hope is that the final bill sent to the President is in keeping with the principles that you outlined and are also outlined by President Clinton.

In my view, H.R. 1200, the McDermott-Conyers plan, does the best job of meeting these objectives. I believe that the single-payer plan is the best way to achieve the President's goals of simplicity, savings, quality, choice and responsibility.

In regard to security, comprehensive benefits that can never be taken away are a cornerstone of both approaches. Both plans provide every legal resident of the United States with a health security card. However, affordability is a key element of security and universal coverage.

Under the Clinton plan, subsidies are limited to individuals and families with incomes of 150 percent of poverty. Currently, our food stamp program already recognizes that the families cannot feed their children for less than 100—until they are up 185 percent of poverty. Thus, we recognize that these families cannot feed their children. Yet we would require them by law to pay large insurance premiums. This is an area in the Clinton plan that must be improved.

If we do not adopt a single-payer plan—I think the evidence will lead us to that—to the single-payer plan. But if we do not, we must make sure that any plan passed by the Congress has a higher threshold for subsidies.

Both the Clinton plan and single-payer plan would accomplish significant cost savings over the next 5 years. However, the single payer bill does so sooner and accomplishes much greater administrative savings. The two authors of the legislation have pointed that out. By eliminating the small group and individual policy insurance market, the Clinton plan is able to make some administrative savings, from about 25 percent to 13 percent.

This is a good start. However, the McDermott bill reduces administrative costs to less than 3 percent, and the savings are directed to expanding benefits to the American people.

As you know, the Congressional Budget Office, as has been mentioned, has estimated that the single-payer approach would save up to \$100 billion per year in administrative costs. The CBO report also concluded that this approach would cut up to \$175 billion a year in health care costs. No other plan can make that claim.

In terms of quality, both the Clinton plan and the McDermott bill would preserve high quality health care. Both plans pay fully for preventive health services. However, the McDermott plan prohibits precertification review, thus eliminating interference between physician and patient. And I think this is a very important feature of the McDermott bill that advocates for its acceptance.

Under the single-payer plan, State quality entities are established to conduct quality reviews based on practice guidelines and profiles. The Clinton plan has no parallel procedure for identifying specific provider quality problems.

Choice of provider. Of all the proposals before Congress, only single payer provides complete freedom of choice of providers. The single payer leaves medical decisions to the doctor and patient rather than putting these decisions in the hands of the insurance companies. Yes, choice is important; and, yes, the single-payer plan gives the greatest choice.

In terms of responsibility, both the Clinton plan and single-payer plan ask everyone, employer and employee, to contribute to the shared responsibility of financing health care costs. The balance of who pays is roughly similar between the Clinton and McDermott bills. However, only the McDermott bill would lower the cost of

health care for 75 percent of the American people. I know the author of the bill made that point. I think it bears repeating.

This is an exciting time, as I mentioned earlier. This committee has great power and a strong role in the decision before the Congress. As Mr. Conyers said, it is historic. We now have a President, and indeed a First Lady, who have placed health care reform and responding to the needs of the American people as a top priority for the Congress.

As your committee gives consideration to the competing bills, I hope you will give very, very strong consideration to the single payer plan. Mr. Chairman, I believe that the McDermott bill meets the criteria that you set out in your opening remarks addressing universal coverage. True universal coverage, credible and fair financing assures affordability, quality of care and provides choice for all Americans. It is an American single-payer plan, and I hope that you will endorse it.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Ms. Pelosi.

[The prepared statement of Ms. Pelosi follows:]

STATEMENT OF
CONGRESSWOMAN NANCY PELOSI
ON HEALTH CARE REFORM AND HR 1200
FEBRUARY 1, 1994

CHAIRMAN WAXMAN, THANK YOU AND THE SUBCOMMITTEE FOR HOLDING THIS HEARING ON HR 1200, THE AMERICAN HEALTH SECURITY ACT. I AM PLEASED TO BE HERE WITH MY COLLEAGUES IN SUPPORT OF A SINGLE-PAYER APPROACH TO HEALTH CARE REFORM.

PRESIDENT CLINTON IS TO BE COMMENDED FOR HIS STATE-OF-THE-UNION ADDRESS WHERE HE MADE CLEAR THE PARAMETERS FOR DEFINING WHAT CONSTITUTES SIGNIFICANT HEALTH CARE REFORM. WE WHO ADVOCATE A SINGLE-PAYER APPROACH SHARE THE PRESIDENT'S COMMITMENT TO ENACTING LEGISLATION WHICH PROVIDES HEALTH INSURANCE COVERAGE FOR ALL AMERICANS BY A DATE CERTAIN.

WE ALSO ARE COMMITTED TO LEGISLATION WHICH CONTROLS THE SKYROCKETING GROWTH IN HEALTH CARE COSTS. LIKE THE PRESIDENT, WE BELIEVE THAT HEALTH CARE REFORM LEGISLATION MUST STAND THE TEST OF CONGRESSIONAL BUDGET OFFICE SCORING FOR CONTROLLING HEALTH CARE COSTS FOR INDIVIDUALS AND THE GOVERNMENT. AS YOU KNOW, ONLY TWO PLANS NOW BEFORE CONGRESS -- THE MCDERMOTT/CONYERS PLAN AND THE CLINTON PLAN -- EITHER MEET OR ARE LIKELY TO MEET BOTH OF THESE GOALS.

MY HOPE IS THAT THE FINAL BILL SENT TO THE PRESIDENT IS IN KEEPING WITH THE PRINCIPLES OUTLINED BY PRESIDENT CLINTON. IN MY VIEW, HR 1200 (MCDERMOTT/CONYERS) DOES THE BEST JOB OF MEETING THESE OBJECTIVES. I BELIEVE THAT THE SINGLE-PAYER PLAN IS THE BEST WAY TO ACHIEVE THE PRESIDENT'S GOALS OF SECURITY, SIMPLICITY, SAVINGS, QUALITY, CHOICE AND RESPONSIBILITY.

SECURITY: SECURITY -- COMPREHENSIVE BENEFITS THAT CAN NEVER BE TAKEN AWAY -- IS A CORNERSTONE OF BOTH APPROACHES. BOTH PLANS PROVIDE EVERY LEGAL RESIDENT OF THE UNITED STATES WITH A HEALTH SECURITY CARD. HOWEVER, AFFORDABILITY IS A KEY ELEMENT OF SECURITY.

UNDER THE CLINTON PLAN, SUBSIDIES ARE LIMITED TO INDIVIDUALS AND FAMILIES WITH INCOME BELOW 150% OF POVERTY. FAMILIES ABOVE THIS INCOME LEVEL WOULD BE REQUIRED TO PAY THE SAME PREMIUMS AS WEALTHY FAMILIES. CURRENTLY, OUR FOOD STAMP PROGRAM COVERS FAMILIES AT 185% OF POVERTY. THUS, WE RECOGNIZE THAT THESE FAMILIES CANNOT FEED THEIR CHILDREN, YET THE CLINTON PLAN WOULD REQUIRE THEM BY LAW TO PAY LARGE INSURANCE PREMIUMS. IF WE DO NOT ADOPT A SINGLE-PAYER PLAN, WE MUST MAKE SURE THE CLINTON PLAN HAS A HIGHER THRESHOLD FOR SUBSIDIES.

OUR APPROACH IS FAIR. THE MCDERMOTT/CONYERS BILL ELIMINATES THE CURRENT TWO-TIERED HEALTH CARE SYSTEM AND FOLDS GOVERNMENT PROGRAMS LIKE MEDICARE AND MEDICAID INTO THE SAME COMPREHENSIVE BENEFITS PACKAGE AS RECEIVED BY OTHER AMERICANS.

SECURITY ALSO REQUIRES COMPREHENSIVE BENEFITS. BOTH THE CLINTON AND THE MCDERMOTT PLANS PROVIDE EXTENSIVE COVERAGE OF HOSPITAL AND PHYSICIAN SERVICES. HOWEVER, UNDER THE SINGLE-PAYER APPROACH, DEDUCTIBLES AND COPAYMENTS -- WHICH ARE OFTEN BEYOND THE ABILITY OF LIMITED INCOME FAMILIES TO PAY -- ARE NOT REQUIRED.

SIMPLICITY: BOTH THE CLINTON PLAN AND THE SINGLE-PAYER PLAN WOULD SIMPLIFY THE BURDEN OF EXCESS PAPERWORK, ADOPT STANDARD CLAIMS FORMS, AND STANDARDIZE BILLING PROCEDURES. BECAUSE THERE ARE NO PREMIUMS, NO DEDUCTIBLES AND NO COPAYMENTS, THE SINGLE-PAYER PLAN IS CONSUMER FRIENDLY. THE CONSUMER DOES NOT HAVE TO FIGURE OUT THE IMPLICATIONS OF SELECTING COMPETING PLANS OR FIGURE OUT COMPLICATED BILLS.

THE ADMINISTRATION OF A SINGLE-PAYER PLAN IS SIMPLE AND CONTRIBUTES TO SAVINGS.

SAVINGS. BOTH THE CLINTON PLAN AND SINGLE-PAYER WOULD ACCOMPLISH SIGNIFICANT COST SAVINGS OVER THE NEXT FIVE YEARS. HOWEVER, THE SINGLE-PAYER BILL DOES SO SOONER AND ACCOMPLISHES MUCH GREATER ADMINISTRATIVE SAVINGS.

BY ELIMINATING THE SMALL-GROUP AND INDIVIDUAL POLICY INSURANCE MARKET, THE CLINTON PLAN IS ABLE TO REDUCE SOME ADMINISTRATIVE EXPENSES -- FROM AROUND 25% TO AROUND 13%. THIS IS A GOOD START. HOWEVER, THE MCDERMOTT BILL REDUCES ADMINISTRATIVE COSTS TO LESS THAN 3% -- AND THE SAVINGS ARE DIRECTED TO EXPANDING BENEFITS FOR THE AMERICAN PEOPLE.

AS YOU KNOW, THE CONGRESSIONAL BUDGET OFFICE HAS ESTIMATED THAT THE SINGLE-PAYER APPROACH WOULD SAVE UP TO \$100 MILLION PER YEAR IN ADMINISTRATIVE SAVINGS. THE CBO REPORT ALSO CONCLUDED THAT THIS APPROACH WOULD CUT UP TO \$175 BILLION A YEAR IN HEALTH CARE COSTS. NO OTHER PLAN CAN MAKE THIS CLAIM.

QUALITY: BOTH THE CLINTON PLAN AND THE MCDERMOTT BILL WOULD PRESERVE HIGH QUALITY HEALTH CARE. BOTH PLANS PAY FULLY FOR PREVENTIVE HEALTH SERVICES. HOWEVER, UNLIKE THE CLINTON PLAN, THE MCDERMOTT BILL PROHIBITS PRE-CERTIFICATION REVIEW, THUS ELIMINATING INTERFERENCE BETWEEN PHYSICIAN AND PATIENT.

UNDER THE SINGLE-PAYER PLAN, STATE QUALITY ENTITIES ARE ESTABLISHED TO CONDUCT QUALITY REVIEWS BASED ON PRACTICE GUIDELINES AND PROFILES. THE CLINTON PLAN HAS NO PARALLEL PROCEDURES FOR IDENTIFYING SPECIFIC PROVIDER QUALITY PROBLEMS.

CHOICE OF PROVIDER: OF ALL THE PROPOSALS BEFORE CONGRESS, ONLY SINGLE-PAYER PROVIDES COMPLETE FREEDOM OF CHOICE OF PROVIDERS. AND ONLY SINGLE-PAYER LEAVES MEDICAL DECISIONS TO THE DOCTOR AND PATIENT RATHER THAN PUTTING THESE DECISIONS IN THE HANDS OF INSURANCE COMPANIES. YES, CHOICE IS IMPORTANT; AND YES, THE SINGLE-PAYER PLAN GIVES THE GREATEST FREEDOM OF CHOICE.

RESPONSIBILITY: BOTH THE CLINTON PLAN AND SINGLE-PAYER ASK EVERYONE -- EMPLOYER AND EMPLOYEE -- TO CONTRIBUTE TO THE SHARED RESPONSIBILITY OF FINANCING HEALTH CARE COSTS. THE BALANCE OF WHO PAYS IS ROUGHLY SIMILAR BETWEEN THE CLINTON AND THE MCDERMOTT BILLS. HOWEVER, ONLY THE MCDERMOTT BILL WOULD LOWER THE COST OF HEALTH CARE FOR 75% OF THE AMERICAN PEOPLE.

THIS IS AN EXCITING TIME IN CONGRESS. WE NOW HAVE A PRESIDENT AND A FIRST LADY WHO HAVE PLACED HEALTH CARE REFORM AND RESPONDING TO THE NEEDS OF THE AMERICAN PEOPLE AS A TOP PRIORITY FOR THE CONGRESS. I URGE YOUR COMMITTEE TO GIVE CAREFUL CONSIDERATION TO THE SINGLE-PAYER PLAN.

Mr. WAXMAN. I want to start the questions myself.

I indicated in my opening statement that this bill does meet the fundamental test of health reform, universal coverage for comprehensive benefits financed in a fair and predictable way. It seems to me that has got to be our objective. That is why I cosponsored this bill along with the President's bill because both would achieve that objective.

Later in the morning we are going to hear from the Health Insurance Association of America, and they are going to tell us that your bill would lead to rationing by queue which they say is the inevitable result of government cost controls. Although HIAA does not mention it, there is plenty of rationing going on right now.

There are millions of Americans who cannot get health insurance due to cherry picking, preexisting condition limits and other discriminatory practices of health insurers. Many of these Americans are all too frequently rationed out of primary care services or life-saving technologies, but the insurance companies believe your bill would make matters worse, and I would like to hear how you respond to that.

Mr. McDERMOTT. Mr. Chairman, you rightly say there is rationing going on today. When a woman has a baby and has to leave the hospital on the same day, decided by an accountant from an insurance company, that is rationing, and it is occurring today. When somebody has a hernia operation and leaves the hospital with a bottle of painkillers on the same day as the operation, that is rationing, decided by insurance companies. When a child has a tonsillectomy and can't be in overnight, that is insurance company rationing. It is going on right now.

Now the issue is, who do you want to be making medical decisions? In Canada, in Germany, in every other industrialized country in the world, the decision about health care is made by the physician with the patient, without an insurance company reaching in and saying you can't do that.

I practiced medicine and had to make phone calls to some 800 number somewhere to talk to some accountant or whatever to get a patient to stay an additional day in a psychiatric unit.

That kind of interference by somebody who does not know anything about the patient is prohibited by our bill. We set up the physicians and the other health care providers as the ones who make the decisions, and they will make ethical decisions on the basis of what is good for their patient, not what is good for the bottom line of an insurance company. And that is where we are headed if we give additional control to insurance companies. They ration already, and it is simply on the basis of a way to save money, not on what is good for people.

Mr. WAXMAN. The President's bill and Mr. Cooper's bill and some other proposals that have been put forward would have us move to what is called managed competition, where the consumers would choose not their doctors but a health care plan with the idea being that consumers will demand more efficiency and good quality in those plans. Do you think that idea is consistent with an approach that you put forward?

Mr. McDERMOTT. Presently, under Medicare, we have the opportunity for people to be either in a fee-for-service system or in a

managed health care system in an HMO. It is possible to have many different ways to deliver health care in an efficient and humane way.

But the idea that you can have competition control in everything simply doesn't face the facts that this is what we had in the free enterprise system for the last 45 years and the cost of health care has risen at two to three times the rate of inflation during that period of time, and they have not controlled. And to think that you can throw all of that into the lap of the consumer and that the consumer will somehow know how to reduce costs by choosing this plan or that plan with a little score card in their hand simply doesn't account for the complexity of the health care system. There is no score card I have ever seen that will give any consumer enough information to make that decision. It really has to be done by health care providers who are aware of what the situation is, and they have to learn to control the costs. And it can be done in this present system with a single-payer method of payment.

Mr. WAXMAN. So a single-payer payment system would allow consumers, if they wanted, to go into managed care or fee for service. The President would have people make the choice between the plans, if they want one kind or another. Mr. Cooper's bill would give them a strong incentive to choose one as opposed to another based on the fact that we are going to tax them or their employer, which I guess would be shifted over to them if they choose something other than the lowest priced HMO. Don't you think that would make consumers more attentive, competition more successful?

Mr. McDERMOTT. Both the President's plan and Mr. Cooper's plan, in my opinion, suffer from the defect of forcing consumers to make a decision over which they do not have enough information. They force them to make decisions based on financial information.

The Cooper bill says that an individual's tax deductibility for health insurance will only be the lowest cost plan in their area. Now, if your company is presently giving you a bigger plan than that, you will have to pay—that will be considered income, and you will be taxed on it on an income tax basis. That is how he gets an income tax increase on most Americans in this country. That is a very heavy hit on the middle class. It is going to force them into the cheapest plan in town.

You in California and other parts of this country have had the experience with cheap HMO's, cheap managed-care operations, and what you get out of that is people who take in money, and everything is designed not to give services. That is how you get the cheapest plan.

When you are competing on the basis of cost and to say to the American people we are going to drive all of you on a financial basis into those kinds of operations, in my opinion, is not necessary nor is it good health care for this country.

Other countries allow patients to choose their physicians, and the doctors and hospitals have to be responsible. In Germany, if the doctors spend too much they reduce their payments. They put the doctors at risk. And I am a physician who believes that doctors ought not to be at risk in the system. They can then manage it efficiently.

Mr. WAXMAN. Thank you, Mr. McDermott.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. McDermott, thank you for coming today. I have one question in two parts.

You are familiar with the fact that the Ontario hospitals closed for 3 weeks in December for all patients except for emergencies. And Canada allows health care costs to grow at a rate of 3.7 percent above the CPI. The Clinton plan would hold our system to the CPI.

My first question: Do you think that is realistic? And, if so, do you think it can be achieved without massive rationing?

Mr. McDERMOTT. Our system is much more generous than the President's system. Their numbers are so tight, I don't think they are going to adequately fund the system. That is one of the reasons why we looked very carefully at our tax package. We would not move on a tax package until we had costs from CBO.

I think the President is going to go through a process of having costs analyzed from CBO and then find that their tax package is not going to be enough. They used CPI rather than the GDP plus population, which is what we used. We allow the growth in the domestic product, plus population per year. They only use CPI, which is the tightest possible cap you can put on it.

Mr. BLILEY. In your statistics, how much above the rate of inflation do you allow for cost increases?

Mr. McDERMOTT. We allow gross domestic product plus population growth at the end of 5 years.

You have got to remember something, Mr. Bliley. I think it is very easy to get us confused with the Canadians, because I am not selling Canadian health care here. There are big problems with that system. The principles are correct but they mix their money. And when they have a deficit, as they are presently having, they take money from health care to pay for roads. That is the reason we set up a health care fund from which the money can only go for health care. I think this is a very important thing to point out.

The second thing is that this country is starting at 17 percent of gross domestic product. Canada is at 9 percent and Germany is at 9 percent. We have so much more money in our system above the Canadians or anyone else; to compare us to them is not a good comparison.

Mr. BLILEY. Where did the number 17 percent come from? I am not saying that is not true, but what we have been hearing is 14.

Mr. McDERMOTT. It is 17 percent by the year 2000. That is what this system, if we did nothing, is going to be at; 17 percent.

Mr. BLILEY. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Dr. McDermott, I hear doctors complain often more and more about insurance companies looking over their shoulder as they practice. Something you alluded to earlier. Contrast, if you would, what H.R. 1200, the impact H.R. 1200 will have on that; contrast with the present system and the other proposals, if you would, including the Clinton health plan.

Mr. McDERMOTT. First of all, let me make one commercial for tomorrow. We are having a "Health Care U" on the single payer system, 2 hours, 9 to 11 a.m., here in the Rayburn building to talk about how our system works. But that is a set-up question for me.

I took these insurance cards out of my wallet. I have Blue Cross/Blue Shield, and if I go to the doctor and the doctor says, Jim, you have to go to the hospital, the first thing I have to do is call my insurance company. I have this 800 number. If I don't call it, it is going to cost me \$500. That is called precertification. Our bill prohibits that.

Under a single payer plan, if a doctor tells you you have to go to the hospital, the first thing you do is pack your bag and go to the hospital. You don't have to be looking at what the insurance company thinks. That is the way it is in Canada, in Germany, in France, and in every other industrialized country in the world.

The doctor and the patient make the decision about what has to happen. In this country we have insurance companies increasingly in the business of deciding the quality of health care in this country. That is why I gave those illustrations.

There are actually insurance plans that will send a baby home before it has had its first feeding. A newborn baby can be sent home without having been fed. That is based on actuarial tables of insurance companies. That kind of influence at those decision levels is simply not good medicine. If your wife, or whatever, went and had a baby, and somebody came into the room and said you have got to take her home because our actuarial chart says she has been here too long, without talking to the doctor, you would be up in arms. But that is exactly what is increasingly happening in this country.

I have nothing against insurance companies. They are simply set up to make money. Their number one driver is the bottom line at the end of quarter so they can pay dividends, and the way you do that is not deliver service. You save money and give it to the stockholders.

And when you set up a system where you are going to get increasing pressure from insurance companies to run HMO's, you are handing to the six or eight biggest insurance companies in this country the power to make the kinds of individual decisions telling doctors, "You can't do this, you can't send people there." "We don't want you to have that kind of treatment." "I don't want that system." I won't vote for that system as a physician. As a Member of Congress, I won't vote for it because I don't want my health care decisions made by an insurance accountant. They are nice people, but they don't know what is the matter with me. That is the simple bottom line.

Mr. BROWN. Dr. McDermott, would—you also contrast one of the major benefits of single payer is the cutting of administrative costs. Would you touch on contrasting what H.R. 1200 does with the other bills? But more to the point, what can we do in the Clinton health plan, because presumably that is going to be more the vehicle than H.R. 1200? What can we do in the Clinton health plan to cut administrative costs further than that plan seems to do?

What elements of single payer can we inject into that plan?

Mr. McDERMOTT. Let me start by questioning your assumption: that the President's plan is the bill that is going to be the one we work off in the Congress.

Ours is the only bill that has been to CBO. Ours is the only bill that has been to Joint Tax. Until you get the President's bill and the Cooper bill and all of these others evaluated on the same basis, I don't think you can make a conclusion that the President's bill is going to be able to get 218 votes to get out of House of Representatives.

Mr. BROWN. Well, I am new around here.

Mr. McDERMOTT. That is why I brought that up.

Mr. BROWN. Somebody told me it might be the President's bill. I don't know where I got that idea.

Mr. McDERMOTT. It is an assumption that some people might make. But I think if you look at it, the real questions here are, "Is the financing adequate in the President's bill? Does he achieve universal coverage?"

All those issues, in my opinion, are yet to be determined. And I think that you and I and every Member of Congress will have a very difficult time going home to people saying, we are going to raise the amount of money that we put into the health care system and we are going to guarantee you less benefits than you presently have today.

There are approximately 60,000 aerospace mechanics in the State of Washington. They have stood in the rain on three different occasions in contract negotiations and have a very generous health benefits package, and for me to go home and say I am not going to guarantee you a package at least as good as what you have now is simply not going to be acceptable.

And that is going to be true for every single person here because you are going to have to look at this as what am I taking home to people that I am going to be able to defend? You might be able to get through the next election because they won't have known quite what is happening.

But 2 years down the road, 1996, if we try and sell them some cut-rate deal run by insurance companies, we are going to be in serious trouble. And I think the politics of it, as well as the numbers, make people look at single payer as the most efficient way to get health care with a generous package, and with the freedom to choose whoever you want to see for your health care. So, I am not willing to concede that the game is over and that we ought to be improving some other plan.

Mr. WAXMAN. If you have another minute, I just want to ask you a challenging question, not that the others haven't been challenging. You said you don't want insurance companies to make the decision as to what care should be given to patients.

But the fact of the matter is we could just put unlimited dollars in giving care and spend all of our money on nothing but health care and in some cases some could argue that is legitimate. So somebody is going to have to say what is appropriate and what isn't.

What I hear you saying is that you don't want an insurance company or entrepreneurs who have set up a plan, a vertically integrated plan, to make that decision when they have a financial in-

terest in turning down people for care, because they want to maximize their profits.

Mr. McDERMOTT. Correct.

Mr. WAXMAN. You feel uncomfortable with that.

On the other hand, if you have a single payer plan, as we have in Medicare and in other countries, there have to be some boundaries set so that we don't pay for everything. So somebody, maybe a government bureaucrat, would make that decision. How comfortable do you feel with that? And aren't we, in fact, going to say that somebody is going to make the decision, shouldn't it be somebody who is publicly accountable as opposed to someone who is self-interested?

Mr. McDERMOTT. There is clearly a limit to how much this country or any country will spend on health care. So we have to deal with limits. So the question is, "Who do you want to be making those decisions?"

Let's take Germany for example. There are doctors and hospitals sitting on one side of the table, and unions, companies, the government, and consumers sitting on the other side, and there is a negotiation about what will be paid for, how much will be paid for. They even allow in some health care plans in Germany that you can spend 2 weeks in a spa.

So you can negotiate anything. And I think that the ability to let a negotiation go on between the physicians and the hospitals and the providers and the people who are the consumers, the unions and the companies and so forth, is the most democratic way to arrive at that decision. To put the health care system in the hands of insurance companies who make the decisions and every doctor works for them, and you either take their rules or you are out, is not a good mechanism, in my opinion. The consumers get left out of that.

How does a consumer fare in an HMO that has a provision in the doctor's contract that the doctor cannot tell the patient about treatments that are not covered by that plan, "I could treat you this way, but our plan doesn't cover that." A doctor can't even say that to a patient? How can you have good health care when decisions like that are made by the management of the company?

I want the consumers to sit eyeball-to-eyeball with the providers and say we think we ought to have this and we think we ought to have that and there is a fixed amount of money. We are already spending so much more than the rest of the world. We are not short of money. We are short of deciding how to spend it efficiently. And I have no fear of sitting across the table and negotiating with the unions and the companies and the consumers of this country in terms what is the best health care system. We would have a much better system than we presently do.

Mr. WAXMAN. Doctors often talk to me about the whole problem of health care because they want to provide the best service for their patients and they want to do what is needed, and they are nervous about government setting the limits on this. Although a lot of them are very nervous at the idea that entrepreneurs putting together health care systems are going to put in gatekeepers who are going to deny people care, and they are certainly frightened that they are going to be coerced into joining those systems because if

they don't, they won't have the ability to continue to practice because their patients will be in these systems.

What do you, as a doctor, say to your fellow doctors who say aren't you setting up a system where the government is going to make these decisions and they say that with a great deal of mistrust, because look at all of the regulations that the government places on them for Medicare and Medicaid.

Mr. McDERMOTT. My answer to that is if you believe that there is going to be a control on the system and the amount of money spent, then the real question is who is at the table to make that decision?

And I, frankly, like the German system better than the Canadian system. The Canadian system has the providers on one side of the table and the government—only the government—on the other side of the table. It is strictly a government-provider negotiation. The German system brings in the consumers, the unions, the companies, and the government. Anybody who purchases gets to sit at the table.

And what I tell the physicians is that you want a seat at the table for those negotiations. You want to be able to sit there and say you ought to be able to spend more money over here and less money there, rather than having it decided somewhere and sent down to you. And it really is a question of getting a seat at the table so that you can argue treatment A is not as effective as treatment B, so we are going to pay for treatment B.

And frankly, the doctors are uncomfortable with this because for the first time in their own history they may have to sit around a table and look at each other and say we are putting too much money over here and we have got to take some of that money and put it over here. But I think that kind of negotiation is better for physicians because at least they have an opportunity to make their case that this is the way it ought to be distributed.

Right now it is decided primarily by insurance companies. And I think as you move to the President's plan, it will be increasingly in the hands of insurance companies. As a doctor, right now if you come to me, I charge you X number of dollars and I get whatever I can from the insurance company and then I chase you for the rest.

Mr. WAXMAN. Under the President's plan, there would be alliances that would act in order to try to make sure that these plans are providing care, that they are pooling everybody together and then they are going to say to the plans, they have got to provide certain benefits but it sounds like those alliances may not be around by the time we get to the end of the day. So that would mean you really are right. The insurance companies will be dealing directly.

I have exceeded my time.

Mr. Brown, do you have any other questions?

Mr. BROWN. One more question, if I could.

One of the oppositions of single payer often cited, kind of along the lines that the chairman did, the one particular example they cite is that the government running the health care system is more of the same kind of the disasters we have seen in running Veterans' hospitals. What is the answer to that?

Without going into great detail about the problems with Veterans' hospitals, what will—will some of the same threads and elements be running through this plan, H.R. 1200, that have been used to run the Veterans' hospitals in the last few decades?

Mr. McDERMOTT. One of the problems in the health care system right now is that there is no system. You have a terribly fragmented system. You have Medicare and Medicaid and you have CHAMPUS and the Veterans' system and you have got all of these systems with everybody trying to shift the cost onto somebody else.

When I was a Ways and Means chairman in my State legislature, they would come in with the Medicaid package and ask for a 15 percent increase. I arbitrarily cut that in half and gave them 7½ percent. I have to fund the State patrol and the State parks, so I am going to cut the request in half and shift the cost on anybody else I can push it off onto.

And everybody has been doing that. So when you look at our present system, you can find problems in Medicare, Medicaid, the Veterans' system, CHAMPUS, any of the programs, because it is not a system. When you talk about a single payer system when everybody is in the same boat, there is no place to shift it.

You stop the cost shifting that is going on in our present system and that is the single biggest advantage from a financial standpoint to a single payer system.

There is no way you get out of shifting it to somebody else because we are all in the same boat. And that is what industry is mad about, right now. They say, "We only want to pay for our employees. We are getting the costs of the uninsured in this country shifted into our health insurance premiums", and they are right. They are paying more than their fair share because we have this big group of people in this country who are not covered by any health insurance plan at all.

So a single payer system says we are all in it together and we are all going to pay the same thing and we are all going to be responsible for it and nobody gets a free ride. And the single payer system is the cheapest and the easiest way to do it. That is why I think the single payer system is the way to go.

Mr. BROWN [presiding]. Thank you very much.

Our second panel includes individuals and groups who are supporting H.R. 1200. Gerard Anderson, School of Hygiene and Public Health, Johns Hopkins University; Sara Nichols is staff attorney for Public Citizen Congress Watch; Carolyn Kazdin is legislative director of Amalgamated Clothing and Textile Workers testifying on behalf of Jack Schinkman, president of ACTWU; Dr. Janet Freedman is the cochair of the Committee on Health Care Reform, American Medical Women's Association.

I welcome you all to the subcommittee and thank you for participating.

Dr. Anderson, would you like to start?

STATEMENTS OF GERARD ANDERSON, DIRECTOR, JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT; SARA S. NICHOLS, STAFF ATTORNEY, PUBLIC CITIZEN CONGRESS WATCH; CAROLYN KAZDIN, LEGISLATIVE DIRECTOR, AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION; AND JANET FREEDMAN, COCHAIR, COMMITTEE ON HEALTH CARE REFORM, AMERICAN MEDICAL WOMEN'S ASSOCIATION

Mr. ANDERSON. Thank you very much. This morning I would like to talk about four design and coverage provisions which distinguish the American Health Security Act from most of the other bills briefly and then discuss in much greater detail the cost containment and the financing aspects.

It has been mentioned earlier, this legislation is the only one that provides comprehensive benefits at relatively low costs, provides universal mandatory health care coverage for all Americans citizens and legal residents.

It is a comprehensive, explicitly defined benefit package covering primary care, acute care, long-term care and mental health benefits. It is able to provide these comprehensive coverage without instituting any cost-sharing.

It integrates the Medicare and Medicaid programs into a comprehensive program and it does it with much lower administrative costs. The Congressional Budget Office says that the cost—the administrative costs will be reduced from 7 percent to 3.5 percent by the year 2000 if this legislation is passed.

In addition, hospitals and other providers would save approximately 6 percent of their revenues by dealing with only one payer and eliminating the copayments and other billing requirements.

However, what I want to do is turn to the financing and cost containment provisions and highlight three areas. First of all, the idea of shifting the method of financing from the private to the public sector; second of all, using price regulation to control health care expenditures; and third of all, using State and local global budgets to control health care expenditures.

By 1997, the American Health Security Act would rechannel approximately \$500 billion from the private sector to the Federal Government by eliminating private sector financing of health insurance and replacing these with an 8.4 percent payroll tax, a 2.1 percent income tax and tax increases on cigarettes and alcohol.

According to my estimates, by 1997, 75 percent of the Americans who are currently insured would pay less for health insurance under the American Health Security Act. According to the Congressional Budget Office, the act would save approximately \$114 billion in the year 2003, and that would result in the American family paying on average \$1,000 less in that area compared to current law.

In my prepared testimony, I prepared a series of four charts showing how the current financing system and the American Health Security Act would affect individual Americans. These charts are based upon the congressional—data from the Congressional Budget Office, Joint Committee on Taxation, Employee Benefit Research Institute and National Medical Expenditure Series.

And if you look at scenario four, it is a 32-year-old male, one child; that child has leukemia, the person is an owner operator of a grocery store, a small firm, \$60,000 in income. Doing well. Having trouble getting insurance coverage and not getting comprehensive health insurance. They are paying \$12,000 right now. Under the American Health Security Act, it would be about \$6,000. So the price could effectively for that individual be cut in half.

It is able to achieve these through administrative savings and through price regulation. Price regulation has been very controversial, as you know, for many years. I recently read a study that was published in the Health Care Financing Review, the arm of the Health Care Financing Administration, and it basically reviewed the literature over the past 20 years that health economists and others have done.

And basically, what I conclude from looking at the literature is that States with all payer rate setting programs have consistently been able to lower the rate of increase in hospital expenditures by 2 to 4 percentage points a year.

I work in Maryland. Maryland has had regulation more than any other State, longer than any other State. Johns Hopkins for the last 3 years has been listed as the best hospital in America. Quality and cost containment can work together. It has been able to reduce the amount of cost shifting. And it has been able to increase access to the uninsured.

There has been little evidence that impact on quality of care has declined. HMO's and other managed care organizations exist in Maryland and other places; the diffusion of technology has done very well. In terms of global budgets, they have been used in other countries for years without access or other problems and they make common sense.

As a society we decide how much we want to spend on defense, space exploration through the budgetary process. No reason why we couldn't do exactly the same thing on health care.

I would be glad to answer any questions.

[The prepared statement of Mr. Anderson follows:]

JOHNS HOPKINS

HEALTH INSTITUTIONS

The Center for Hospital Finance and Management

624 North Broadway / Third Floor
Baltimore MD 21205
410/955 2300 FAX: 410/955 2301

Mr. Chairman, my name is Gerard Anderson, and I am the Director of the Johns Hopkins Center for Hospital Finance and Management, co-Director of the Johns Hopkins Program for Medical Practice and Technology Assessment, and an Associate Professor of Health Policy and Management at the Johns Hopkins School of Hygiene and Public Health.

Today, I wish to speak in favor of H.R. 1200, the "American Health Security Act." The Act contains numerous provisions that should be incorporated into the final health care reform legislation. There are four coverage and design provisions that warrant special mention:

- Universal, mandatory health insurance coverage for all citizens and legal residents. Many of the other bills under consideration do not achieve this minimum standard.
- A comprehensive, explicitly defined benefit package covering primary care, acute care, long term care, and mental health benefits. The American Health Security Act is able to provide these comprehensive health benefits without instituting cost sharing.
- Integration of the Medicare and Medicaid programs into one comprehensive plan. Maintenance of two or more health care financing systems will increase administrative costs without improving the health status of any American.
- Much lower administrative costs. According to the Congressional Budget Office, the administrative costs under the American Health Care Security Act will decrease from the current 7 percent of health spending to 3.5 percent by the year 2000. CBO also estimates that hospitals, physicians, home health agencies, and other health care professionals would save 6 percent of revenue by dealing with only one payer and eliminating copayments and other billing arrangements.

Financing and Cost Containment

The most controversial and innovative aspects of the American Health Security Act, however, involve its financing and cost containment provisions. In my testimony this morning, I would like to concentrate on three specific issues:

- Shifting the method of financing from the private to the public sector.
- Using price regulation to control health expenditures.
- Using state and national global budgets to contain health care expenditures.

Public Financing

In 1997, the American Health Security Act will rechannel approximately \$500 billion from the private sector to the federal government by eliminating private sector financing of health insurance and replacing the funds with an 8.4 percent payroll tax, a 2.1 percent income tax, and tax increases on cigarettes and alcohol. While many pundits have suggested that such a large tax increase makes this proposal dead on arrival, the method of financing a single payer plan has considerable merit after reviewing the data and comparing it to the current method of financing health care.

In 1997, 75 percent of Americans who are currently insured would pay less for health insurance under the American Health Security Act than under current law and this percentage would increase as the cost savings projected under the American Health Security Act would increase. According to projections made by the Congressional Budget Office, the American Health Care Security Act would save \$114 billion in the year 2003 and, therefore, the average American family would pay over \$1000 less for health care services in the year 2003 compared to current law.

I have prepared a series of charts that illustrate how the financing system would affect individual Americans. The charts show that under the American Health Security Act most Americans would pay less than they are currently paying for health care. For low income individuals and individual with chronic illnesses the amounts would be significantly less. The charts also show that most employers would pay less if the American Health Security Act were passed. The charts are based upon numbers generated by the Congressional Budget Office, Joint Committee on Taxation, Employee Benefits Research Institute, and the National Medical Expenditure Series.

Price Regulation

Under the American Health Security Act, hospitals and nursing homes will be paid on the basis of global budgets. Physicians and other health care professionals will be paid based on a variety of mechanisms including annual operating budgets, fee schedules, and capitation payments.

While no one prefers price regulation to a free market solution, international and domestic evaluations of price regulation in the health care industry have shown that price regulation is able to control costs without an adverse impact on either access to or quality of medical care. In 1991, I wrote an article in the Health Care Financing Review summarizing the published literature on all payer rate setting. The article reached the following conclusions:

- States with all payer rate setting programs have been able to consistently lower the rate of increase in hospital expenditures by 2-4 percentage points per year compared to other states.
- All payer rate setting programs have been able to reduce the extent of cost shifting considerably.
- All payer rate setting programs have increased access for the uninsured because they compensate hospitals for the care of people without health insurance.
- Most studies have found no evidence that quality of care declined under all payer rate setting programs.
- HMOs and other managed care organizations have prospered in states with all payer rate setting.
- The diffusion of new technology and access to capital is comparable in states with and without all payer rate setting.

The Prospective Payment Assessment Commission, the Physician Payment Review Commission, and the Congressional Budget Office have recently conducted independent assessments of the feasibility of regulating hospital and physician services based upon Medicare payment rules. They all concluded that a national payment rate is feasible at this time.

State and National Budgets

The American Health Security Act establishes an annual global budget for health care, limiting growth in expenditures to the rate of growth in the gross domestic product. Each state is given a global budget which the state will use to set budgets for physicians, hospitals, and nursing homes. Separate budgets for new construction, renovation, and major capital equipment are

allocated directly by the states. A National Health Board negotiates prescription drug prices with drug companies.

Global budgets have been used by other countries for years without access or quality problems. In the United States, a number of states have, for years, used a form of global budgeting - prospective rates with volume adjustments - to set hospital rates without adverse effects on quality of care or access to care. Medicare currently uses a form of global budgeting for physician services.

Global budgets also make common sense. As a society we decide how much we want to spend on defense, space exploration, or public education through the budget process. There is no reason why the same process could not be used to decide how much to spend on health care.

I would be happy to answer any questions.

SCENARIO 1

WORKER IN SMALL MANUFACTURING COMPANY

Demographics:

- 1 Age: 45
- 2 Gender: Male
- 3 Family: Wife and two children
- 4 Health Status: No preexisting conditions
No long term health care needs
- 5 Income: Wages - \$50,000 in 1999, no other income
- 6 Health Habits: Non smoker, non drinker

Current Health Insurance Coverage:

- 1 Benefits: Comprehensive benefits; no deductibles;
Rx drugs with copay; no dental; no
long term care
- 2 Coverage: Family
- 3 Employer Payment: Employer pays 100% of premium

COST TO THE WORKER

	Out of Pocket	Premium	Taxes	Total
Current System	200 ⁽¹⁾	5435 ⁽²⁾	0	5635
American Health Care Security Act	0 ⁽²⁾	0	5250 ⁽⁴⁾	5250

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.87 percent of payroll in manufacturing firms with fewer than 10 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative assumption is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

Payments for Health
Insurance

Current System	5435 ⁽²⁾
American Health Care Security Act	4200 ⁽²⁾

⁽¹⁾ Assume the average payroll in 1999 is \$50,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.87 percent of payroll in manufacturing firms with fewer than 10 employees.

⁽³⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent.

SCENARIO 2

WORKER IN MEDIUM SIZED TRANSPORTATION FIRM

Demographics:

1	Age:	42
2	Gender:	Female
3	Family:	Divorced, two children
4	Health Status:	No preexisting conditions No long term health care needs
5	Income:	\$20,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	\$1000 family deductible; no Rx; no dental; no vision
2	Coverage:	Family
3	Employer Payment:	Employer pays 80% of premium

COST TO THE WORKER

	<u>Out of Pocket</u>	<u>Premium</u>	<u>Taxes</u>	<u>Total</u>
Current System	3330 ⁽¹⁾	2130 ⁽³⁾	0	5460
American Health Care Security Act	0 ⁽²⁾	0	800 ⁽⁴⁾	800

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.65 percent of payroll in a transportation firm of between 25 and 99 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative estimate is that this percentage will not change.

⁽⁴⁾ For employers of less than 75 full time equivalent employees earning an average wage of less than \$24,000, the Joint Committee on Taxation has projected a tax rate of 4.0 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

Payments for Health
Insurance

Current System	2130 ⁽²⁾
American Health Care Security Act	800 ⁽³⁾

⁽¹⁾ Assumes the average payroll in 1999 is \$20,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.65 percent of payroll in a transportation firm of between 25 and 99 employees.

⁽³⁾ For employers of less than 75 full time equivalent employees earning an average wage of less than \$24,000, the Joint Committee on Taxation has projected a tax rate of 4.0 percent would raise the required amount of revenue.

SCENARIO 3

WORKER IN LARGE CONSUMER PRODUCTS FIRM

Demographics:

1	Age:	58
2	Gender:	Male
3	Family:	Married with no dependents
4	Health Status:	No preexisting conditions No long term health care needs
5	Income:	\$60,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	Comprehensive; \$200 deductible; drugs; dental; vision
2	Coverage:	Family
3	Employer Payment:	Employer pays 100% of premium

COST TO THE WORKER

	Out of Pocket	Premium	Taxes	Total
Current System	1218 ⁽¹⁾	6876 ⁽²⁾	0	8094
American Health Care Security Act	0 ⁽²⁾	0	6300 ⁽⁴⁾	6300

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the HMEES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 11.46 percent of payroll in a consumer products firm employing 500-999 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative estimate is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

	Payments for Health Insurance
Current System	6876 ⁽²⁾
American Health Care Security Act	6300 ⁽³⁾

⁽¹⁾ Assumes an average payroll in 1999 of 160,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 11.46 percent of payroll in a consumer products firm employing 500-999 employees.

⁽³⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent.

SCENARIO 4

WORKER IN OWNER OPERATED GROCERY STORE

Demographics:

1	Age:	32
2	Gender:	Male
3	Family:	Married with one child
4	Health Status:	Child with chronic leukemia
5	Income:	\$60,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	Medium Option: Basic coverage; \$500 deductible; no dental; Rx drugs Included; \$3000 out of pocket limit; 3 month waiting period for preexisting condition
2	Coverage:	Family: Major Risk Medical Insurance
3	Employer Payment:	Owner operator pays 100%

COST TO THE EMPLOYER

	Out of Pocket	Premium	Taxes	Total
Current System	6922 ⁽¹⁾	5394 ⁽²⁾	0	12316
American Health Care Security Act	0 ⁽²⁾	0	6300 ⁽⁴⁾	6300

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 8.93 percent of payroll in wholesale and retail trade firms with fewer than 10 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative assumption is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

Mr. BROWN. Thank you. Ms. Nichols.

STATEMENT OF SARA S. NICHOLS

Ms. NICHOLS. Thank you, Mr. Brown, for holding these hearings.

My name is Sara Nichols and I am the staff attorney with Public Citizens Congress Watch. We very much would like to applaud the President for his laudable goals of simplicity, security, savings, choice and quality. But unfortunately, we have to tell you that the managed competition structure he has chosen is unable to deliver on those goals.

The only plan before the American Congress that can deliver on those goals is the single payer plan, the American Health Security Act, H.R. 1200.

It is a simple plan that covers everyone. And since everybody who has gone so far has already talked about the way in which the American Health Security Act improves on the Canadian system, I don't want to repeat those. But I applaud the sponsors for learning from the successes and failures of the Canadian system and making this truly an American Health Security Act.

There has been a lot of attention to improving our health care system and using the increased funding we have, nearly 30 percent more per person that we spend in this country than in Canada to provide better benefits and make sure that card that you take to a doctor actually gets to something because there is a doctor there and there is a facility there where there may not have been one before.

I would like to focus mostly on the way in which the American Health Security Act contrasts with the President's plan in terms of fulfilling the President's laudable goals, simplicity, security, savings, choice, and quality, and of course the nonnegotiable demand for universal coverage. Only the American Health Security Act fulfills these goals.

The American Health Security Act single payer system is very simple. Couldn't be more simple. One plan for everyone with high benefits. Everyone pays in. And everyone gets out.

The Clinton-backed plan by contrast is so complex as to be virtually unexplainable. Instead of removing a layer of bureaucracy, the insurance industry, it inserts two new layers between you and your doctor, the health alliance and the HMO if you presently weren't in one.

The single payer system saves more than any other plan before the U.S. Congress and is the only plan which can save enough to deliver on universal coverage now. There is no evidence that the Clinton plan can deliver on its promises or save enough. And in fact it relies on competition to bring down costs. That competition simply will not work in that manner.

Right now, the big five insurance companies own 45 percent of the HMO's in this country. Managed competition will only accelerate the trend of these insurance companies to own and operate HMO's, and so there will really be only a few large companies dominating the field, and when you have an oligopoly like that, instead of competing to bring down the price of health care, they actually act in concert to raise the price of health care so they all

have a bigger piece of pie. We know that is the way that oligopolies act.

The American Health Security Act goes with you, not with your spouse or where you work or where you live. And so it is ultimately secure. It is from cradle to grave and womb to tomb. But the Clinton health care plan is not secure because it is employer-based and underfunded. If it were sufficiently funded to deliver on its promises it would be more secure, but it isn't because it doesn't save enough.

And finally, the most important feature of the Canadian and single payer system is that it is the ultimate in choice. You have full choice of a physician anywhere in the country, whereas the Clinton plan, by design, is restricted choice in order to save money herding consumers into the HMO's away from the more expensive fee for service option.

The most important misnomer is that the Clinton plan is more market-based somehow than the single payer American Health Security Act. In fact, both plans rely on a mixture of public sector and private sector to achieve their goals. The American Health Security Act combines the best of the public sector, public sector fair financing with the best of the private sector, which is entrepreneurial private medicine.

The Clinton health care plan combines inefficient private sector financing with intrusion into—government intrusion into delivery of health care. The single payer system in the American Health Security Act is, therefore, the best and least intrusive option for the American medical and political system.

Thank you.

[Testimony resumes on p. 612.]

[The prepared statement of Ms. Nichols follows:]

STATEMENT OF SARA S. NICHOLS
PUBLIC CITIZEN'S CONGRESS WATCH

I. INTRODUCTION

My name is Sara Nichols, I am a staff attorney and health lobbyist with Public Citizen's Congress Watch. Thank you Chairman Waxman and to the other members of this committee for allowing me to testify on the American Health Security Act.

According to numerous studies by the Congressional Budget Office (CBO), single payer is the only health reform option before the Congress that has been shown to save money and deliver health coverage to every resident *simultaneously*. As such, a single payer plan is the only plan that can deliver on the President's nonnegotiable demand for universal coverage.

The American Health Security Act, H.R. 1200, introduced by Representatives Jim McDermott (D-WA) and John Conyers (D-MI) along with 90 other cosponsors, is the piece of legislation before the House of Representatives which best represents the single payer system.

Not only is H.R. 1200 the only reform before the Congress which actually provides universal coverage, it's the only legislation which fulfills the other laudable principles set forth by the President but not delivered by the President's plan: security, simplicity, savings, quality and choice.

Single payer is simple: everyone's in the same plan. It provides security because it is not employer-based. It saves more money than any other plan according to the General Accounting Office (GAO) and the CBO and provides full choice of provider. The President's plan is complex, saves little money, and therefore provides no security and little choice.

1 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

Unfortunately, neither H.R. 1200 nor the President's plan significantly improves the quality of medical care.

The most important thing to understand about the single payer system is that despite constant misstatements to the contrary, single payer is not government-run health care, it is government-financed health care with full and free choice of doctor.

While the Canadian system provides an excellent model for an American health system, it is possible to improve on the Canadian system. H.R. 1200 has done just that. Its sponsors learned from Canada's successes, and its mistakes, and they have adapted the bill to the American health care crisis and system. Although it could adopt still more from the Canadian experience, H.R. 1200, as we will demonstrate, is truly the *American Health Security Act*.

II. THE SINGLE PAYER SYSTEM

The basic notion of single payer is very simple. The "single payer" refers only to the financing of health care. The inefficient wasteful multiplicative financing of the nearly 1500 private health insurers is replaced by a single government insurance fund. All of the private expenditures currently in the health care system are converted to public financing collected through the tax system.

The primary model for the single payer system which we rely on in this country is the Canadian system. There are other nations in the world that have workable universal national health care programs. While features of these other systems could no doubt play a role in any good health care system here, we think the single payer Canadian-style system is the most adaptable to the American palate

2 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

because it is *government-financed*, not *government-run*. The distinction is important.

In a *government-run* system doctors work for and hospitals are owned and operated by the government. The often-derided British health care system is an example of this model. In contrast, in a single payer system like Canada's, the claims are processed by the government, but the doctors work for themselves and hospitals are privately owned and operated.

While Americans can be easily convinced of the merits of a public insurance fund over 1500 private insurance funds, they would be much more skeptical about the idea of providers, clinics and hospitals being government-owned and operated.

It is incorrect to think of the Clinton health plan as more market-based than the single payer plan. In fact, both plans depend on a mixture of the public and private sectors to achieve health system reform. In our estimate a single payer system combines the best of the public sector--fair financing--with the best of the private sector--entrepreneurial private practice medicine. The Clinton health plan, on the other hand, combines inefficient private sector financing with intrusive government restructuring of the health delivery system. The single payer plan is the better and less intrusive option for the American medical and political system.

A. Universal Coverage. Single payer has as its most basic feature universal coverage because single payer starts with the premise that health care is a right; neither a benefit, nor a privilege, but a right. If health care is a right, our government has a duty to provide basic health services to all its residents, not just the rich ones or the poor ones, nor the employed ones nor the unemployed ones, nor

3 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

only the legal residents. *Under single payer, all the residents of the United States could be covered fully for the same amount we are spending now.*

B. Cost Controls. Single payer is the only health reform before the Congress which controls costs enough to cover every person in this country fully for the same amount we are spending now. In 1993, health care bureaucracy consumed 24.7 cents of every health care dollar, \$232.3 billion.¹ By switching to a single-payer system, we could have saved in 1993 at least \$117.7 billion; \$456 for every American, or \$3,325 per uninsured person. These savings include \$49.1 billion (60.1 percent) on hospital administration,² \$23.8 billion (28.3 percent) on overhead in doctors' offices, \$1.6 billion (13.3 percent) on nursing home administration, and 34.2 billion (79.6 percent) on insurance overhead.³ This is enough to fund universal access for the uninsured and improve benefits for the tens of millions of Americans who currently have only partial coverage without any increase in overall health spending.

Single payer would achieve savings in insurance overhead by replacing the nearly 1500 private payers of health insurance claims with one "payer," the federal government. The hospital administrative savings come from global operating

¹Hellander, Ida M.D., Himmelstein, David M.D., Woolhandler, Steffie, M.D., M.P.H. and Wolfe, Sidney, M.D., "Health Care Paper Chase, 1993: the Cost to the Nation, the States and the District of Columbia," from *Physicians for a National Health Program*, Chicago, IL; The Center for a National Health Program Studies, Harvard Medical School/The Cambridge Hospital, Cambridge, MA; and The Public Citizen Health Research Group, Washington, D.C.—August 1993.

²Woolhandler, Himmelstein, *New England Journal of Medicine*, August, 1993.

³*Ibid.*, "Health Care Paper Chase."

budgets and reduced billing costs associated with direct reimbursement by the government.

And finally, the single payer system, like every universal coverage health care system in the developed world, controls costs by negotiating providers' fees, and pharmaceutical costs.

C. Comprehensive Benefits. Single payer is the only health reform system before the Congress that can afford to provide comprehensive benefits. Because single payer controls costs better than any other system, it allows us to stretch dollars further getting as much value as possible from our phenomenal health spending.

In 1993, Canada spent 38 percent less per person than the U.S. did and was able to guarantee every Canadian comprehensive major medical coverage including full primary care treatment. Because we spend so much more, we can afford to provide better benefits than in many provinces in Canada, benefits like mental health coverage, full long term care and dental coverage. Since we can afford it if we use our money more efficiently, we should provide what everyone really needs, not just the bare minimum. We need full coverage for all the people in this country, not just the few who can afford it.

D. Accessibility. Single payer is fully accessible. There are no financial barriers to care or treatment. There are no copayments or deductibles in a true single payer system. Because there are no such "cost-sharing" provisions, people can go to the doctor whenever they need to, not just when they can afford to.

The Clinton plan, in contrast, relies heavily on shifting costs to health

consumers, requiring families to pay as much as \$3,000 a year out of pocket on top of 20% copayments. These cost shifts create an illusion of lower premiums and health costs while simply forcing consumers to pay three additional ways, through their taxes, through lost wages and through out-of-pocket expenses.

Some argue that we can't afford to break down these barriers, that we *need* cost-sharing in order to bring in more revenue and deter people from seeking unnecessary care. The reality is that by paying into a tax-based system, we all are sharing costs. We all will need to access the health care system at some point in our lives. So-called "cost-sharing" deters as much needed care as it does unnecessary care and in so doing drives up the cost of health care because by the time people come to the doctor, they are generally sicker and more expensive to treat.⁴

E. Freedom of Choice. Single payer allows people full choice of provider, even improving over the current choices people have in this country. In a single payer system, you're provided with a health security card. That card guarantees you full coverage at the provider of your choice. You take that card to the provider of your choice anywhere in the country and you're covered. The provider sends the bill to the government instead of billing you and your insurance company.

In contrast, the Clinton Health Security Card does not guarantee *coverage*. It guarantees only universal *access*. The difference between access and coverage is important. In theory, everyone has *access* to the finest hotel in town, but only if you

⁴Rassell, Edith, Ph.D.—Economic Policy Institute.

have the money to pay. In our current health care system, the insurance companies restrict both *access* and *coverage*. The Clinton health plan cures only the access question, without providing coverage.

F. **Portability.** A single payer system is fully portable. Instead of coverage being dependent on where you work, who you're married to, or where you live, your coverage goes with you and stays with you, no matter where or whether you work.

G. **Public Accountability.** A single payer system is publicly accountable. Instead of decisions about your health needs being made by insurance bureaucrats, decisions are made by accountable, fairly-comprised health boards which are answerable to the public through the political system.

III. CANADA'S VERSION OF SINGLE PAYER

The Canadian version of single payer is most illustrative of what we want to provide here because it works, it's close to home, and Americans have heard about it.

The Canadian system is able to deliver universal health care to all its residents with no barriers to receiving care, and it does so at 38% less per person than the cost of the American system.

A. Federal Minimums. In Canada, the single payer system evolved from province to province, and the administration of the systems varies by province. But there are certain features that never vary:

1. Copayments, deductibles and other "cost-sharing" devices are barred by law;
2. Provinces have local health boards which negotiate fees with

7 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

physicians and drug companies;

3. Provinces have mandated separate capital and operating budgets;

and

4. Hospitals run on global operating budgets which are determined on a capitated basis (based on the number of patients served).

B. Provincial Jurisdiction. While the Canadian federal government provides these basic standards, it allows other features to be controlled and determined at the provincial level. Some examples of provincial discretion include:

1. The extent of the benefits provided;

2. Whether the physician is reimbursed on a strictly fee-for-service basis or a salaried basis; and

3. How much money is allocated to capital development such as the building of new high tech equipment, etc., vs. allocation to operating expenses.

In all, the single payer system, modelled on Canada, is not just the best plan for consumers, but the only plan that provides what consumers need.

IV. H.R. 1200, AMERICAN HEALTH SECURITY ACT

H.R. 1200 takes the basics of the Canadian health care system and adapts it to the United States. Most of the familiar features of the Canadian system make the journey intact: H.R. 1200 provides comprehensive benefits for all Americans for the same amount we are spending now to cover only a portion of the population. It does so not only by replacing the inefficient private insurance financing with public financing, but by employing global operating budgets for hospitals, and insuring

8 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

negotiated fee schedules for providers and drug companies. In all, H.R. 1200 is the best representation of a single payer system currently before the Congress, containing the only structure capable of guaranteeing health care to the nation.

In this section, because I have already extolled the virtues of a single payer system, I will concentrate on the ways in which H.R. 1200 improves on the Canadian system and point out a few places where it falls short. While the foundations of this house are sound, we aim to take a closer look at its curtains and furnishings as well.

A. Decentralization. H.R. 1200 adapts itself to the American political and economic system by decentralizing the running of the business of health care. Under H.R. 1200, while the federal government would collect the premiums and set minimum standards for benefits and allocation of resources, it is up to the state and local governments to decide how to use those resources, beyond a standard benefit package.

There are aspects of this decentralization which are excellent. In general, it is preferable for states and local communities to make decisions with regard to the fair allocation of resources rather than the federal government. In theory, as long as those decisions are publicly accountable, the resources stand a good chance of being fairly distributed, especially when compared to the current health care system.

Nonetheless, there are some basic aspects to a single payer system which must not be left up to the states, they must be set by the federal government. The most important central principle which is left out of H.R. 1200 is the principle of *mandated* separate capital and operating budgets for hospitals and other health providing

9 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

institutions.

H.R. 1200 fails to mandate such separate budgets. Instead, it specifies simply that states must have budgets for capital and operating expenses and leaves it up to the states to decide whether to merge or split these budgets.

Granting latitude in this area subverts a fundamental precept of a successful single payer system: namely, that without this mandate of separate budgeting of capital and operating expenses, there is no guarantee of halting the out-of-control "medical arms race" which has eaten up our health care resources and dramatically increased the cost of medical care.

Unless capital and operating expenses are paid for and budgeted for separately, nothing is to prevent the local health boards set up by H.R. 1200 from siphoning off money badly needed to operate existing facilities and devoting it instead to building yet another lavish duplicative facility aimed at attracting wealthy patients. We must ensure that basic medical facilities and equipment are kept well-staffed and running smoothly before we turn toward expanding machinery and facilities in a given metropolitan area and worsening the wasteful current situation in which there are 300,000 empty hospital beds in the U.S.. *H.R. 1200 must be amended to match its companion bill in the Senate, S.491, which mandates separate capital and operating expenses.*

B. More comprehensive coverage. While most provinces in Canada have made the decision to guarantee at the federal level only major medical expenses, we can afford more coverage than that here because we spend nearly one-third as much

10 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

per person per annum as they do in Canada.

H.R. 1200 has gone a long way towards providing those comprehensive benefits. It federally guarantees full major medical coverage, prescription drug coverage, a basic package of mental health benefits, dental care for children up to 18, and long term care and home and community-based coverage for those who meet the requirements. States are free to provide benefits beyond the federal package, but they cannot choose to cover less than the federal minimum.

Although we applaud the high level of medical benefits guaranteed by the U.S. government in relation to Canada, we think we can and should do better. We have enough money in the system to eliminate the arbitrarily low cap on mental health benefits, to provide dental care for all Americans, and to provide long term care (especially home-based care) for people who need assistance with only one Activity of Daily Living (ADL), instead of 2, as the bill provides.

C. Increasing the number of primary care practitioners. H.R. 1200 recognizes that giving everyone a health security card to present to the provider of his or her choice is meaningless if no such provider is available and accessible.

In fact, we have a critical shortage in this country of primary care practitioners that Canada does not have. 2/3 of the physicians in this country are specialists to 1/3 primary care practitioners. In most other developed nations including Canada, the ratios are reversed, 2/3 primary care practitioners to 1/3 specialists. Reversing these ratios here would not only increase the availability of the providers whom patients need most and most often, but it would further bring down the cost of

11 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

health care by encouraging earlier and less expensive care over costly specialized medicine.

H.R. 1200 has sought to address this problem by setting strong goals for the national health board to work towards and establishing funding for those goals.

Some of those methods include:

1. Within 5 years of enactment, 50% of the residents in medical residency education programs will be primary care residents;
2. The national board will reduce payments to state health security programs that fail to meet this goal;
3. The bill also seeks to increase the number and use of clinical primary care practitioners, certified nurse midwives, physician assistants and other non-physician practitioners; and
4. The bill revives and uses the National Health Services Corps and Public Health Block Grants to accomplish these goals.

D. Increasing the number of primary care facilities. Another problem with our current health care system is a critical lack of facilities and medical personnel in poorer areas in our inner cities and in many sparsely populated and poor rural areas. H.R. 1200 seeks to increase the number of good primary facilities in previously underserved communities in the following ways:

1. Establishing block grants to develop primary care centers which will serve medically underserved populations. Such centers would include migrant health centers, community health centers or other qualified health centers.

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2. The bill also encourages and creates Community Health Service Organizations (CHSOs) to serve previously underserved communities and areas. These CHSOs are basically qualified HMOs which are designed to fill the vacuum created by a lack of health facilities.

Although we applaud any effort to create facilities and service for previously underserved communities, we fear the CHSOs will not work because the bill allows them to be for-profit entities. Any feature which encourages for-profit HMOs to start and flourish in the future is anti-consumer in effect. In order to maximize profits, for-profit HMOs tend to divert money earmarked for care to profit, engage in excessive marketing, and pay high executive salaries, all at the expense of care. In general, HMOs and other managed care facilities attempt to save money by reducing the amount of care provided. There is no evidence that such efforts consistently control costs. Global operating budgets and negotiated fee schedules control costs.

Unfortunately, the legislation distinctly fails to forbid profiteering at the expense of care. In the companion legislation in the Senate, S. 491, there is a provision that specifically forbids the creation of new for-profit HMOs and ensures that existing for-profit facilities cannot divert excess dollars to profit over a reasonable rate of return on their capital investments. This arrangement has already proved successful with not-for-profit hospitals in the U.S.. *To fulfill its goals, H.R. 1200 must be amended to include such provisions.*

E. Universal Coverage. H.R. 1200 saves enough money to provide universal coverage *immediately upon enactment*, rather than "when the savings are achieved," as

13 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

the Clinton plan provides. Any plan which defers universal coverage to a time in the future--even a specified time--is insufficient to address our current health care crisis. The Clinton plan, because it does not save enough money now, projects universal coverage into the next millennium. This is unacceptable and doomed to failure.

The experience of Massachusetts is illustrative. In 1988, the Massachusetts legislature passed a health reform plan based on the so-called "pay or play" model. The idea was that universal coverage would kick in once sufficient savings were realized. Because the plan had woefully insufficient cost controls, the savings were never realized. 6 years later Massachusetts suffers from nearly the highest health costs in the country, one of the highest penetrations of HMOs, and has given up on achieving universal coverage with that system. H.R. 1200 fulfills the essential goal of saving enough money to provide universal coverage immediately.

Although H.R. 1200 saves enough money to cover everyone, it actually leaves at least 3.2 million people out. One area where H.R. 1200 does not improve on the Canadian system is in its definition of universal coverage. The bill has confined its coverage to *legal* residents of this country, rather than all residents. This is ultimately a self-defeating and unworkable distinction.

To take seriously the idea that health care is a right, rather than a privilege or a benefit, means providing health coverage to all people who reside in this country regardless of immigration status. It is immoral, unethical and unjust to exclude the 3.2 million undocumented workers of this country and their families from our health services. We cannot say "one plan for all," and then define the "all" as we like.

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Since the system will eventually pay for sick undocumented residents one way or another, it would be far cheaper on the system to provide full coverage including preventive medicine. Allowing any group of patients to be excluded from "universal" coverage creates the same expensive cost-shifting as the status quo.

We are already paying for the care of undocumented immigrants. In 1993, it cost the United States government \$300 million to provide emergency care to undocumented workers in Texas, California, New York and Illinois alone. Study after study shows that undocumented residents, like all of the uninsured, use our health care system whether covered or not. They show up at emergency rooms about to give birth to an unhealthy baby or they arrive in the advance stages of a debilitating disease and our hospitals treat them, because they must. If those hospitals and medical personnel are not reimbursed for treating undocumented people, it strains our resources and puts an added burden on state and local governments to pick up the tab.

Undocumented workers contribute to our economy. They buy goods and services, they pay rent and often they even pay taxes. According to the Center for Constitutional Rights in New York, the amount they contribute to our economy outweighs or counterbalances the cost of providing health services to them. Yet because of xenophobia and lack of leadership, we seek to deny them care.

Ironically, if for no other reason, we should cover undocumented immigrants out of fear. Diseases know no boundaries of legality. A sick undocumented child resident can infect your child as easily as a documented child. To protect all the

15 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

legal residents of this country we must provide health coverage to the undocumented.

F. Public Accountability. H.R. 1200 dictates the composition of local health boards ensuring a balance of consumer, physician and medical industry representation on the boards. There is also an attempt to achieve nonpartisan balance on the federal boards. These efforts are to be applauded because they represent a dramatic increase over our current health care system in the amount of accountability to the public.

The public accountability portions of the bill would be strengthened greatly by facilitating the creation of an independent consumer-funded watchdog organization modelled on the successful consumer utility board (CUB). Such a watchdog, funded by voluntary contributions, would monitor local health boards, insuring that they were accountable to the public.

G. Financing. Because a new financing section to H.R. 1200 was introduced just last Thursday, we have not had a chance to review it thoroughly. Our initial impression, however, is favorable. Again adapting to the American political realities, the bill relies primarily on a payroll tax which is capped at a percentage of payroll depending on the size of the business. The new package has eliminated the increases in the top income tax brackets which the old funding package had included. It has added a \$2 cigarette tax and a 50 percent excise tax on handguns and ammunition.

In general, an income tax is preferable to a payroll tax as a funding mechanism

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because it is progressive rather than taxing at a flat rate. However, when compared to an employer mandate such as the Clinton bill contains, a graduated payroll tax like this is much less regressive.

The \$2-per-pack cigarette tax increase is very necessary and long-overdue. Such an increase would reduce the number of smokers over time, particularly by discouraging people from ever starting smoking. We applaud its inclusion, and that of the gun tax, in the bill.

H. **Quality.** H.R. 1200 is the only health reform bill currently before the Congress that does nothing to *lessen* the quality of medical care by restricting consumers' legal rights.

V. COMPARING H.R. 1200 TO THE CLINTON BILL

In setting forth his proposal for health care reform, President Clinton established several laudable goals for what such reform should achieve, namely: simplicity, security, savings, choice and quality. Unfortunately, the Clinton Health Security Act is structurally incapable of achieving those goals. The only health reform proposal before the Congress which achieves these goals is H.R. 1200/S.491, the American Health Security Act.

A. **Simplicity.** H.R. 1200, the single payer plan, is *simple*; everyone is in the same plan, with the same benefits, no matter where they live, work or what their income level. In contrast, the Clinton health plan is so complicated as to be virtually unexplainable, to say nothing of the expenses of funding these "complications."

Rather than removing bureaucracies, the plan inserts two new layers--the health

17 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

alliances and the HMOs—between you and your doctor.

The Clinton plan is confusing and unfair because it establishes and institutionalizes different tiers of care depending on one's income, age and place of employment. Seniors continue to receive Medicare; Medicaid recipients go into the new system with reduced benefits; people buy care through newly created "health alliances;" the level of care depends on ability to pay for more expensive "fee-for-service" care and if you can't, you have to join an HMO. Large employers can opt out of the plan altogether.

If people and businesses cannot afford to pay their health premiums, they are subsidized (as soon as the savings are achieved and then for as long as they last) by the federal government. The Health Alliances have to figure out how much to subsidize each person based on their income level, the size of their business, etc. If the subsidy was wrong it will have to be adjusted retroactively. The amount of complexity these contingencies generate is difficult to overestimate. The Clinton plan could not be less simple.

B. Savings. H.R. 1200 would save upwards of \$117 billion in administrative waste and more by going to a single payer system and by setting global budgets and fees. According to figures released by Rep. McDermott last week, 75% of consumers would pay *less* out of pocket for health care than they do now. Single payer saves money.

Soon we will know from the Congressional Budget Office exactly how much savings the Clinton plan can produce. Preliminary estimates show the plan achieving

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marginal savings by "streamlining" the insurance paperwork--\$6 to \$8 billion a year. At the same time, the Clinton plan adds a cost of \$21 billion a year to pay for the new layer of bureaucracy--the health alliances.⁵

Competition amongst health plans provides illusory savings at best. Managed competition will hasten the existing trend in this direction. Already 45% of all HMOs are owned by the 5 largest insurance companies--CIGNA, Aetna, Prudential, The Travellers, and MetLife.⁶ Because it is likely that the plans will eventually be owned by only a few giant corporations, an oligopoly will result. Oligopolies have no incentive to compete; they instead act in concert to enlarge the size of the pie so that they can all have a bigger piece of it.

Furthermore, the plan contains no global operating budgets, and no negotiated fee schedules for physicians or pharmaceuticals (outside of the government-controlled Medicare which is squeezed to find new money to fund the uninsured). The plan is virtually incapable of saving enough money to cover the new people it hopes to bring in.

On an individual level, there is little in the way of savings either. Individual consumers will have to pay high out-of-pocket expenses in the form of co-payments and deductibles. Although estimates on the individual savings vary, it is clear that the number of people who will pay less under the Clinton plan for health care does

⁵Himmelstein, David and Woolhandler, Steffie, 1993.

⁶Known as "the Alliance for Managed Competition."

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not begin to approach the 75 percent of us who will pay less under H.R. 1200. The Clinton plan does not produce sufficient savings to pay for universal coverage.

In contrast, the CBO and General Accounting Office (GAO) have consistently found not only that single payer is the only health reform before the Congress which saves money, but it is the only plan which saves money while providing universal coverage *simultaneously*.

C. Security. H.R. 1200 provides complete security because coverage goes with the person not her job, her spouse or her place of residence. All are covered under H.R. 1200 from cradle to grave and no one can take it away.

Because it is employer-based and under-funded, the Clinton health care plan cannot provide Americans with badly-needed health security. As long as the type, extent and quality of health care coverage received is dependent on employment status, we're all at risk because we may lose or change our jobs. The Clinton health care plan depends entirely on employers to cover the workers of this country. The rest of us are financed by money (nearly \$285 billion) which is siphoned from the Medicare system by "slowing its growth rate." Such financing is so flimsy that it reinforces rather than alleviates the current insecurity of Americans about their health care.

D. Choice. Perhaps the biggest fallacy about a single payer system is that it would restrict choice. H.R. 1200 provides a real choice of provider because consumers can take their Health Security Card to the doctor of their choice. They can also go to an HMO or managed care facility if they prefer. Plans and doctors

20 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

compete on the basis of quality, rather than cost. Managed care and fee-for-service medicine will only survive if consumers choose to go to them.

By design, the Clinton health care system restricts choice of provider. The main cost controls in the plan come from encouraging people to leave traditional fee-for-service plans and enter managed care plans. By making the fee-for-service option more expensive than HMOs, the Clinton plan would herd people into HMOs and away from free choice of doctor, unless they are wealthy enough to afford the other option. The President himself emphasizes choice of *plan* over choice of *provider*, acknowledging that the choice of provider is limited in his plan. What consumers really cherish is choice of provider not plan. Single payer provides that choice.

E. **Quality.** While the Clinton bill restricts consumers' legal rights to restitution from negligent providers, H.R. 1200 preserves consumers' rights and for that we applaud its sponsors.

Unfortunately, the applause ends there. Like all current Congressional health care proposals, *both* plans have ignored the vital concern of affirmatively protecting consumers from negligent providers. Although many plans pursue "quality assurance" through anonymous data collection, practice guidelines, and protocols, there are no provisions for meaningful regulation of the medical profession. Congress should pursue an affirmative agenda of consumer protection highlighted by medical malpractice prevention and consumer empowerment.

Specific suggestions include:

1. Reducing the number of unnecessary deaths and injuries caused by

21 - Nichols testimony before Health and the Environment Subcommittee of House Energy and Commerce Committee

negligent medical treatment by creating a comprehensive medical malpractice prevention program;

2. Developing independent, publicly-accountable state medical boards;
3. Establishing more stringent physician licensing and discipline

procedures;

4. Empowering health consumers by mandating reporting of information regarding incompetent health care providers; and

5. Authorizing consumer access to information regarding health care providers through the taxpayer-funded National Practitioner Data Bank.

VI. CONCLUSION

H.R. 1200, the American Health Security Act, is, despite some flaws, the best representation of a single payer system before the House of Representatives. More importantly, it is the only plan before the Congress capable of fulfilling the President's nonnegotiable demand of universal coverage.

In crafting this bill, the sponsors of H.R. 1200 have ingeniously adopted the strengths of the Canadian-system, while eliminating its few weaknesses.

As a *government-financed system with full choice of doctor* rather than a *government-run system without, single payer* is uniquely adaptable to the American system. In it, we could have competition which truly benefits consumers, between doctors on the basis of quality rather than between HMOs on the basis of cost.

Mr. WAXMAN. Thank you very much for your testimony. I would like to now call on Carolyn Kazdin.

STATEMENT OF CAROLYN KAZDIN

Ms. KAZDIN. Good morning. I am Carolyn Kazdin. I am here today representing our president Jack Schinkman.

The Amalgamated Clothing and Textile Workers Union is acutely aware of the health care crisis in America. We have members in inner cities in the north and many rural areas in the south who have trouble finding a doctor, despite the fact that they have a health plan.

Escalating health care costs threaten the competitiveness of our companies, strain the collective bargaining system, and dominate government budgets at all levels. The current system of health care financing puts our firms and their domestic plants at a serious disadvantage in the global economy threatening our members' very livelihood.

Therefore, ACTWU is guided by three fundamental principles as we evaluate proposals for reform: One, the need to provide comprehensive quality care for everyone.

Two, the need to eliminate waste in the health care system and effectively contain costs.

Three, the need to share the financial burden of health care equitably. That means progressive public financing, where corporations and wealthy individuals pay more than small employers and wage earners.

The American Health Security Act, H.R. 1200, is the only bill that fully satisfies these needs. We are particularly concerned about competitive issues and equitable financing in health care. H.R. 1200 fully addresses these needs, as well.

Through our experience in collective bargaining and organizing, ACTWU is confronted daily with the competitive distortions that result from some companies providing health insurance for their workers while others do not. Nonunion firms often provide partial or no coverage or require copayments on coverage for dependents that is prohibitively expensive.

For example, before they unionized, single mothers making curtains for Kmart at the S. Lichtenberg Company in Georgia were taking home \$150 a week. The company charged them \$68 a month if they wanted to cover their children under an insurance policy with a \$500 deductible. After paying for food and shelter, almost none of the 530 workers were able to pay for family coverage.

In their first union contract, the company and workers joined the national ACTWU health plan with affordable premium rates, no premium payments by the workers and a \$200 deductible. Hundreds of children have been protected by health insurance for the first time. Now the company has to find other ways to compete with certain firms that have the noninsuring edge.

There are many ways that firms are that insuring workers are hurt by those who don't insure their workers. First, the noninsuring firms have lower operating costs and can underbid firms with insurance. Second, the insuring firms end up covering the spouses and dependents who work for noninsuring firms. Third, cost shifting by health care providers means that insuring firms ac-

tually pay the bills of employees of noninsuring firms. And finally, to the extent that the government picks up the bills of uninsured, all taxpayers, including insuring firms, pick up the tab for noninsuring firms.

H.R. 1200 would remove the competitive edge currently enjoyed by those firms that foist their workers' health care bills onto other companies and taxpayers. Given the current profit incentives, nothing short of a mandatory universal system can guarantee that all employers make a fair contribution to coverage and that all workers and their dependents are insured. This will take 85 percent of the currently uninsured who are the employees and their dependents of noninsuring firms.

We negotiate health plans with hundreds of small businesses, so we feel obligated to counter the hysteria that is being whipped up against mandatory employer contributions by some small business organizations. These are the same groups that said increasing the minimum wage would close businesses and kill jobs. But the actual minimum wage increases in 1990 caused no job loss. Now they are saying that mandatory premiums, no matter how small, will close businesses and kill jobs. They are wrong this time, too. Small businesses can afford insurance if it is equitably financed.

While we feel very strongly that all firms should provide insurance for all their employees, we know that charging the same flat premium can create new competitive problems. It could threaten the viability of some labor-intensive, low profit margin firms from apparel companies to retail stores, and would continue to put U.S. firms at a competitive disadvantage internationally.

ACTWU negotiates contracts both in the United States and in Canada. We can cite many examples of a single payer system providing the same or better coverage for less. In 1992, Levi Strauss paid premiums equal to 19 percent of its Florence, KY, payroll in the plant there, but paid an amount equal to under 4 percent its Stoney Creek, Ontario, Canada payroll for similar comprehensive health insurance.

For textile company Courtalds PLC paid the difference of 22 percent in Alabama versus 6 percent in Ontario. Two Hathaway shirt plants of the Warnaco Company, the difference was 12 percent in Maine and 4 percent in Ontario. I have other examples in my testimony of the competitive distortions that this kind of health care provides.

We are proud to be here today endorsing H.R. 1200, not only because it would provide equitable financing of health care, but also because it would eliminate waste, control costs, and use resources wisely to provide comprehensive quality care for everyone.

Thank you very much, Mr. Chairman.

[The prepared statement of Ms. Kazdin follows:]

STATEMENT OF
AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION

The Amalgamated Clothing and Textile Workers Union is acutely aware of the health care crisis in America. When we organize a non-union plant, we usually find workers and their families with no insurance, inadequate insurance or unaffordable insurance. We have members in inner cities in the North and rural areas in the South who have trouble finding a doctor despite the fact that they have a health plan. Escalating health care costs threaten the competitiveness of our companies, strain the collective bargaining system and dominate government budgets at all levels. The current regressive system of health care financing puts our firms and their domestic plants at a serious disadvantage in the global economy, threatening our members' very livelihood. Effective health care reform must come to grips with all these dimensions of the health care crisis.

Therefore, ACTWU is guided by three fundamental principles as we evaluate proposals for reform:

1. The need to provide comprehensive, quality health care for everyone. Employed and unemployed. Young and old. Rich and poor.
2. The need to eliminate waste in the health care system and effectively contain costs. The plan must reduce administrative waste and put a lid on rising medical costs.
3. The need to share the financial burden of health care equitably. That means progressive public financing, where corporations and wealthy individuals pay more than small employers and wage earners.

The American Health Security Act, HR 1200, is the only bill that fully satisfies these needs. It moves away from the employer-based insurance system toward a national social insurance system. It takes all the administrative waste from thousands of separate insurance plans and puts that money into a comprehensive benefit package that includes long-term care. It provides meaningful cost containment through an internationally proven method of bargaining with providers. It addresses issues of quality control without micromanaging health care professionals and without compromising patients' freedom to choose their doctors and hospitals. It provides funding and incentives to get more doctors into inner cities and rural areas. It assures public accountability of the health care system.

ACTWU is delighted to support this legislation for all these reasons. But we are particularly concerned about competitive issues and equitable financing in health care reform. HR 1200 fully addresses these issues as well.

Equitably Financed Universal Coverage Is Needed

ACTWU members, like millions of working Americans who now have insurance, are suffering the consequences of a health care system in which some employers get away with providing little or no insurance for their employees and dependents. This system puts socially responsible companies at an unfair and serious competitive disadvantage. And that means lost wages and lost jobs for insured workers. ACTWU firms with insurance are also paying more than companies in other countries with less expensive universal health care systems.

As low wage workers in the textile and apparel industry who are representative of low wage workers in general, ACTWU members are also concerned that universal health care be progressively financed, like their own union plan, using a percentage of payroll formula. The overall current health care financing structure is highly regressive for companies and workers. Health care reform needs to reverse that pattern so that universal coverage does not create new competitive problems for companies or severe hardship for workers.

HR 1200 would create a universal health care system with equitable financing. This would eliminate the unfair competitive advantage held by those firms who deny health insurance to their workers. Such a system would also bolster U.S. competitiveness with those countries that have affordable universal coverage.

Current System Distorts Competitiveness

Through our experience in collective bargaining and organizing, the Amalgamated Clothing and Textile Workers Union is confronted daily with the competitive distortions that result from some companies providing health insurance for their workers while others do not. Non-union firms often provide partial or no coverage or require co-payments on coverage for dependents that is prohibitively expensive. For example, before they unionized, single mothers making curtains for K-Mart at the S. Lichtenberg Company in Georgia were taking home \$150 a week. The company charged them \$68 a month if they wanted to cover their children under an insurance policy with a \$500 deductible. After paying for food and shelter, almost none of the 530 workers were able to buy family coverage. In their first union contract, the company and workers joined the national ACTWU health plan with an affordable "community" rate, no premium payments by workers and a \$200 deductible. Hundreds of children became protected by health insurance for the first time. Now the company has to find other ways to compete with curtain firms that have the non-insuring edge.

There are many ways that insuring firms are hurt by those who don't insure their workers. First, the non-insuring firms have lower operating costs and can underbid firms with insurance. Second, the insuring firms end up covering the spouses and dependents who work for non-insuring firms. This includes wives who work in retail stores and husbands or college students who work for small businesses. (About 65% of retail employees and 31% of firms with 10 or fewer workers had no company insurance in 1992.¹) Third, cost shifting by health care providers means that insuring firms actually pay the bills of employees of non-insuring firms. (About 30% of private insurance hospital bill payments cover nonreimbursed expenses of other patients.²) Finally, to the extent that the government pays the bills of the uninsured, all taxpayers, including insuring companies, pick up the tab for non-insuring firms.

HR 1200 would remove the competitive edge currently enjoyed by those firms that foist their workers' health care bills onto other companies and

¹ Employee Benefit Research Institute, EBRI Issue Brief (EBRI tabulations of 1993 Current Population Survey), January 1994.

² Economic Policy Institute, "The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity, and Exports", 1993.

taxpayers. Given the countervailing profit incentives, nothing short of a mandatory universal system can guarantee that all employers make a fair contribution to coverage and that all workers and their dependents are insured. This will take care of 85% of the currently uninsured who are the employees (and their dependents) of non-insuring firms. It also follows in the footsteps of mandatory Social Security contributions by virtually all employers.

We negotiate health plans with hundreds of small businesses. So we feel obligated to counter the hysteria that is being whipped up against mandatory employer contributions by some small business organizations. These are the same groups that said increasing the minimum wage would close businesses and kill jobs. But the actual minimum wage increases in 1990 caused no job loss.³ Now they're saying that mandatory premiums, no matter how small, will close businesses and kill jobs. They're wrong this time, too. Small business can afford insurance if it's equitably financed.

Equitable Financing is Key to Equitable Employer Mandate

While we feel very strongly that all firms should provide insurance for all their employees, we know that charging the same flat premium to every company could create new competitive problems. It could threaten the viability of some labor-intensive, low-profit-margin firms from apparel companies to retail stores. It would also continue to put U.S. firms at a competitive disadvantage internationally.

ACTWU negotiates contracts in both U.S. and Canada. We can cite many of examples of a single payer system providing the same or better coverage for less. In 1992 Levi Strauss paid premiums equal to 19% of its Florence, Kentucky plant payroll but paid an amount equal to only 4% of its Stoney Creek, Ontario (Canada) payroll for similarly comprehensive health insurance. For textile company Courtalds PLC the difference was 22% (Alabama) vs. 6% (Ontario); for two Hathaway shirt plants of the Warnaco Company the difference was 12% (Maine) vs. 4% (Ontario). A similar cost gap exists between the largest U.S. men's suit manufacturer, Hartmarx, and its Canadian competitor, Peerless, which is exporting almost 300,000 suits to the U.S. annually. Canada's pre-eminence as the largest exporter of men's wool suits to the U.S. is helped in part by Canada's less expensive national health insurance.

Charging the same high flat premium to all workers threatens the already tenuous living standards of low-wage workers. Currently, workers can't afford to buy insurance once they've paid for food and shelter. How will they feed and house their families if the premiums become mandatory and their incomes remain the same? The high price and unfair distribution of health care costs in the current system is the engine that drives firms and individuals to drop coverage. HR 1200's payroll premium would solve this problem.

³ Ibid

Current Health Care Financing Is Regressive

The current financing of health care is extremely regressive. A recent study found that low-income families pay over twice the share of income for all health care expenses as high-income families.⁴ As a share of income, low-income families spend four times as much as high income families for premiums, even though many poor families are uninsured and don't pay any premiums. Out-of-pocket spending is even more regressive, with low-income families spending nine times what high-income families spend even though poor people can't afford to spend much at all on uncovered bills and deductibles.

The only portion of health care financing that is equitable is the portion covering programs that are paid for through personal and corporate income taxes at the Federal and state level. But other taxes, such as sales taxes, hit low-income families harder.

The Fairest Financing Method Is Also the Simplest

The majority of health care is funded through premiums and out-of-pocket spending--the two most regressive forms of financing. Fortunately, the most equitable method for financing health care, a payroll premium by firms and workers, is also the simplest to administer.

Traditional insurance premiums are flat dollar amounts that by their nature are a greater burden for low-income people. This burden is made even heavier by having different rates based on family size--the more mouths you have to feed, the higher your insurance premium. Under the current system, contingent workers--part-timers, temporaries and independent contractors--pay higher individual premiums than employees in group plans even though they often have lower incomes. Finally, smaller firms pay higher rates than larger ones.

HR 1200 provides the most equitable and simplest solution to financing health care: transforming per capita premiums into a progressive payroll premium structured like Social Security. The combination of a 8.4% payroll premium for companies (4% for small/low wage firms) plus a 2.1% payroll premium for workers would cover the costs now covered by regressive flat premiums and out-of-pocket payments.

These 8.4% and 4% payroll premiums are fair to a wide range of companies and workers. It represents significant savings for most companies that now insure their workers and a reasonable cost for those that do not. It is in line with amounts paid by our competitors in the developed nations. It automatically covers most contingent workers.

The Clinton plan creates a hybrid premium in the form of a flat rate with a payroll payment maximum of 7.9% for companies and 3.9% for individuals. These caps, along with the subsidies for small businesses and the very poor, make premium financing less regressive than the current system. But it creates a system that is much more cumbersome than a progressive payroll premium. This hybrid premium would require several billion dollars each year in

⁴ Edith Rasell, Jared Bernstein, and Kainan Tang, "The Impact of Health Care Financing on Family Budgets," Economic Policy Institute, 1993.

unnecessary administrative costs to determine employment status, family structure, employment status of dependents, and which firms and individuals are eligible for how much of a subsidy. While simplicity is supposed to be one principle of the Clinton plan, its financing is much more complex than it needs to be.

Cost Sharing Is Not Justified

The other highly regressive component of health care financing is out-of-pocket expenses, including deductibles, co-payments for premiums, uninsured portion of bills, and uncovered services (often drugs and mental health care). People with low incomes can't afford to buy the health care they need. Yet they pay almost a nine-times larger portion of their income out-of-pocket than high-income families for the health care they get. Furthermore, a single catastrophic illness can propel even middle-income families into bankruptcy due to uncovered bills.

Increasing out-of-pocket burdens have been advanced as a cost containment measure and a means to reduce unnecessary use of medical services. But, it is not clear that America overuses health care compared to our international competitors. Americans go to the doctor less and stay in hospitals a shorter period of time than consumers in every other major industrialized country. These nations get more services for less money despite universal coverage and little or no cost-sharing.

What is clear is that co-payments and deductibles discourage 24% of people with insurance from seeking the care they feel they need.⁵ What is also clear is that low-income people in America have worse health when they are subjected to cost-sharing. Americans who can't afford to go to a doctor put it off till they land in a hospital emergency room where more expensive heroic measures have a much lower chance of actually providing a cure.

Many union and non-union workers do not currently pay a portion of premium costs. Our union has seen too many families in unorganized plants "choose" not to have coverage simply because they couldn't afford it. As a result, we have insisted that our largest national tailored clothing and cotton shirt and jeans contracts have fully-employer-paid insurance.

HR 1200 uses payroll premiums to fully fund health care without any deductibles or co-payments for insurance or for medical services. This is similar to systems among our international competitors. Cost containment and the problem of inappropriate care are addressed without creating financial barriers to necessary services. We feel this bill incorporates the best way to finance health care and the most effective cost containment mechanism.

HR 1200 provides a free choice of provider and does not force workers into managed care and HMOs. Under the Clinton plan, we are concerned about how large a gap there will be between HMO, PPO and fee-for-service premiums. We fear the creation of a Medicaid-type second tier system of HMOs with low quality care and no middle-class constituency.

⁵ Mark D. Smith, Drew E. Altman, Robert Leitman, Thomas W. Moloney, and Humphrey Taylor, "Taking the Public's Pulse on Health System Reform", Health Affairs, Summer 1992, p. 130.

Any New Taxes Should Be Fair

Payroll premiums fall only on wages and salaries and do not impact non-labor income such as dividends, interest and rents. Equitable financing of health care therefore should include some payments based on total income or non-labor income. Excise taxes, such as the proposed cigarette tax, are the most regressive taxes of all. A cigarette tax would take a 72 times greater share of family income from the lowest 20% of families compared to the top 1% of families. While a cigarette tax has some justification as a health measure, it must be counter-balanced with less regressive financing provisions.

Conclusion

We heartily endorse HR 1200 not only because it would provide equitable financing for health care, but also because it would eliminate waste, control costs and use resources wisely to provide comprehensive, quality health care for everyone.

Mr. WAXMAN. Thank you. Dr. Freedman.

STATEMENT OF JANET FREEDMAN

Ms. FREEDMAN. Good morning, Mr. Chairman.

My name is Dr. Janet Freedman, and I am testifying today on behalf of the American Medical Women's Association, AMWA, the National Organization of Women Physicians and Medical Students. I am an assistant professor of rehabilitation medicine at Bellevue Hospital in New York City, our Nation's oldest public hospital.

AMWA is grateful for the opportunity to voice support today for the principles of H.R. 1200, the American Health Security Act.

We were founded in 1915 to promote women's health and to support women in medicine. We believe there is an urgent need for health care reform. As women physicians, we are faced with the shortcomings of today's health care system. As women patients, we are faced with the same problem as we try to seek care for ourselves and our families.

We see the myriad ways in which our Nation's patients are not receiving adequate care and we bear the brunt of the increased bureaucratic intrusion into basic medical decision-making. AMWA has identified three essential goals for health care reform. They are going to sound very familiar in this room this morning: universal access, administrative simplification, and autonomy of clinical decision-making for physicians.

Last November, our house of delegates voted to support a single payer system as the optimal way to achieve these three goals. One month later we joined nine other physician organizations at the White House to support the historic effort by President Clinton and Hillary Clinton to secure quality health care for all Americans. We do not believe that our support for both proposals is mutually exclusive, rather the McDermott and Clinton plans differ in structure, their ultimate goals do parallel one another, as well as AMWA's.

H.R. 1200 achieves universal access to care, regardless of where a patient lives, works, or how much she or he earns. Universal coverage is especially important for women who make up the majority of the part-time and low wage work force and are more likely to be insured through their spouses. Nearly 12 million women have no insurance of any kind and because children are often covered by their mothers, our Nation's children lack coverage.

Removal of barriers for women has extremely broad and positive implications for care delivery for all Americans. This is the only plan before Congress, other than the Clinton proposal, which guarantees a specific list of benefits including prevention and primary care. Without detailing the specific services, we cannot hope for true reform and we cannot take the leap of faith that other plans are asking that are not describing their services. Nor can we accurately determine the cost of the new health care system if the benefits are not defined.

AMWA particularly applauds the inclusion of a full range of reproductive services for women, including abortion.

The single payer system outlined in H.R. 1200 also takes the exceptional strides of simplifying the multilayer bureaucracy, which

is currently crippling the way that physicians deliver care. There is no medical reason for multiple insurance plans.

Today we practice within a system of 1,500 insurance companies which have thousands of plans, and managed care entities with a maze of ever-changing rules. We are pressured by for-profit entities to see more and more patients each hour and physicians are spending 20 to 25 percent of our time filling out paperwork rather than caring for our patients. Much of the time we lose is in administrative duties spent justifying treatment to third parties, which in turn are second-guessing the care that we are giving. You have heard some testimony about that today.

And the estimates from the Congressional Budget Office on money saved really represents totally how much totally unnecessary administrative cost we have and much of that is the time spent by physicians and others justifying care.

By placing the responsibility of medical decision-making back in the hands of medical personnel by eliminating precertification requirements, H.R. 1200 does us and our patients an exceptional service. One of the most crucial provisions for assuring flexibility of care is the establishment of a definitive mechanism for tracking outcome data and adapting to emerging health trends.

Our body of knowledge is constantly evolving and this is especially true in the area of women's health where the scientific community is only beginning to address the gaps in our understanding of women's needs. And we owe a great debt to you, Mr. Chairman, for your leading role in making sure that our research institutions fill in those gaps. It is imperative that our new health care play a part in this evolving body of knowledge.

H.R. 1200's provisions for collecting outcome data, emphasis on preventive and primary care, will ultimately prove cost effective but that will take some time. We also agree with H.R. 1200's \$2 per pack excise tax on tobacco. This is not only life-saving, but also cost-saving.

The American Medical Women's Association welcomes this subcommittee's scrutiny of the current obstacles facing physicians and patients in today's health care system. The single payer system proposal, although seemingly dramatic, offers an excellent opportunity for change. AMWA looks forward to helping to enact H.R. 1200's principles for comprehensive, universal reform.

[The prepared statement of Ms. Freedman follows:]

STATEMENT OF JANET FREEDMAN
AMERICAN MEDICAL WOMEN'S ASSOCIATION

Good morning Mr. Chairman and Members of the subcommittee. Thank you for the opportunity to appear before you today. I am Dr. Janet Freedman, and I am testifying on behalf of the American Medical Women's Association (AMWA), a national organization of women physicians and medical students. I currently serve as Co-Chair of AMWA's Committee on Health Care Reform. I am also Assistant Professor of Rehabilitation Medicine at Bellevue Hospital in New York, the nation's oldest public hospital. AMWA is delighted to voice its support for the principles of Representative Jim McDermott's legislation, H.R. 1200, the American Health Security Act.

AMWA was founded in 1915 to promote women's health and to support women in medicine. AMWA's 13,000 members practice in virtually every medical specialty and practice setting -- from private practice to research to academia. Let me begin by saying that we are frankly incredulous at the recent suggestion by some members of Congress that the need for reform is not urgent, that the American health care system is not in crisis. Without question, the dilemma which faces us today is not whether there *is* a crisis, but *what action* we are willing to take right now to remedy the glaring inequities and inefficiencies of our current system. Although it is true that the United States boasts the world's best physicians, medical education programs, hospitals, and technologies, the mere existence of such quality should not be confused with its availability to all citizens.

AMWA is uniquely positioned to comment on the need for reform. As women seeking care for ourselves and our families, we are consistently faced with the shortcomings

of today's health care system in dealing with our own diverse needs as patients. As women physicians, our numbers are concentrated in areas of the medical field which deliver primary care services, specifically internal medicine, family medicine, pediatrics, and obstetrics/gynecology. Consequently, we address daily the fundamental health needs which all Americans share, we see the myriad ways in which our nation's patients are not receiving adequate health care, and we bear the brunt of the increased bureaucratic intrusion into basic medical decisionmaking.

Through surveys of our membership, AMWA has identified three overarching goals of health care reform, which are essential to assure quality patient care and the health of our nation, and serve as our criteria for assessing the many proposals before Congress: universal access; administrative simplification; and autonomy of clinical decisionmaking for physicians.

Last November, AMWA's House of Delegates voted to support a single-payer system as the optimal way to achieve these three goals. One month later, we joined nine other physician organizations at the White House to support the ambitious, historic effort by President Clinton and Hillary Rodham Clinton to secure quality health care for all Americans. We do not believe our support for both proposals is mutually exclusive; rather, although the McDermott and Clinton plans differ substantially in their structure, their ultimate goals parallel one another's as well as AMWA's, and we will continue to voice strong support for these basic tenets as essential to achieving any real reform in this country.

Access to Comprehensive Health Care

H.R. 1200 takes dramatic action to achieve access to health care which is universal, regardless of where a patient lives, works, or how much she or he earns. The elimination of barriers to needed services assures that all Americans will receive a universal standard of care. AMWA is especially supportive of the principle of universal coverage in light of women's vulnerability under the current system. Women earn less than men, make up the majority of the part-time workforce and the low-wage service and clerical workforces, and are more likely than men to be insured through their spouses. Nearly twelve million women have no health insurance of any kind. Furthermore, because women are the primary caregivers to our nation's children, a lack of health coverage for women often translates into a lack of coverage for entire families. Thus, removal of barriers for women has extremely broad, positive implications for care delivery to all Americans.

H.R. 1200 is the only plan before Congress, other than the Clinton proposal, which guarantees a specific, comprehensive list of benefits. AMWA is firm that without this specificity of services, Americans cannot hope for true reform. We can not afford the dangerous leap of faith being asked by other congressional proposals which provide no details for covered services. Nor can we accurately determine the cost of a new health care system if the covered benefits are not first defined.

The McDermott plan's emphasis upon preventive and primary care services is vital, both for decreasing the need for expensive acute care and for improving the overall health of

the American public. Additionally, the proposal assures coverage for care in a variety of settings, such as community-based and home-based care, and with a variety of providers, which both improve access and lower costs. AMWA strongly supports the appropriate utilization of the skills of all members of the health care team.

AMWA particularly applauds H.R. 1200's inclusion of the full range of reproductive health services for women, including abortion. As women physicians from a broad range of religious and philosophical backgrounds, AMWA members are firm in their belief that the abortion decision is a private medical matter between a patient and her physician. To exclude or restrict abortion coverage under an otherwise comprehensive standard benefits package is not only medically illogical; it is dangerous public health policy. Diminished coverage necessarily leads to delayed or denied health care, posing significant risk to the pregnant patient.

Administrative Simplification and Streamlining

With its creation of a single National Health Security Standards Board, topic-specific advisory committees, and a single claim form, the health care system outlined by H.R. 1200 also takes exceptional strides toward simplifying a bureaucracy which is frankly crippling the way in which we physicians deliver care to our patients. Today, we practice within a labyrinthine system of approximately 1500 insurance companies, thousands of benefits plans, and managed care entities with a maze of ever-changing protocols. We are pressured to see more and more patients in each hour of the day. It is now estimated that most physicians

spend approximately 20 to 25% of their time filling out paperwork rather than caring for real people.

The development of a communicative, long-term physician-patient relationship is vital to good care delivery and good health. AMWA is proud of the studies -- most recently in the *New England Journal of Medicine* -- which have borne out what we have personally believed for years: women physicians excel at fostering these relationships. Thus, the mounting administrative duties which demonstrably limit the time we spend with patients have been especially troubling to our members.

Indeed, H.R. 1200's estimated savings in administrative costs are an accurate indication of the degree of third party intervention which physicians now face, and offer one of the strongest arguments in favor of a single-payer system. These substantial savings projections were borne out by a Congressional Budget Office report released last month, predicting up to \$100 billion in annual savings. With more money and time available for patient care, we physicians will finally be able to devote ourselves to doing what we do best: provide quality care for patients.

Autonomy for Physicians and Patients Alike

Much of the time physicians lose to administrative duties is spent justifying treatments to third parties which in turn second-guess the care we are delivering. Women physicians have become, unfortunately, all too aware that the cognitive care and preventive procedures

we are celebrated for providing are neither financially rewarded, nor encouraged, when the entity making the decisions is motivated by profit, not patient well-being. Indeed, many a well-intentioned physician has made clinical decisions against her own judgment in order to avoid protracted disputes with third party payers. By placing the responsibility for medical decisionmaking back in the hands of those personnel trained to do it, H.R. 1200 does us and our patients an exceptional service.

At the same time that the single-payer system frees physicians from crushing administrative duties, patients under the single-payer system are also given new latitude in choosing a physician. In our experience as practitioners, AMWA members have observed that a patient who is in control of this most basic decision -- whom to choose for medical care -- is a patient who will select a doctor she trusts and whose advice she will take seriously. A patient who can choose a provider most convenient to her home or office is a patient more likely to seek care early, and on a regular basis, rather than waiting until a serious health problem develops and forces the need for care. Choice of physician is not, as some have suggested, an "extra" benefit which patients should not expect or demand; rather, it is vital to assuring that patients access the health care system in a consistent, effective way.

A final note about physician autonomy: One of H.R. 1200's most crucial provisions for assuring the flexibility of physician care is its establishment of an American Health Security Quality Council, offering a definitive mechanism for tracking outcomes data and adapting to emerging health care trends. Our body of knowledge about preventive measures,

treatments, screenings, and other medical procedures is constantly evolving. This is especially pertinent in the area of women's health, where the scientific community is only just beginning to address many of the gaps in our understanding of women's needs.

AMWA's membership, and all American women, owe a great debt to you, Chairman Waxman, for your leading role in making sure that our research institutions fill in those gaps. It is imperative that our new health care system also play a part in this evolving body of knowledge. Physicians must have the freedom to develop and implement new protocols in light of scientific progress. Women physicians look forward to playing an active role on the American Health Security Quality Council and related bodies to assure equal representation of all patients' interests.

H.R. 1200's provisions for collecting outcomes data, along with its emphasis on preventive and primary care, will ultimately prove immensely cost-effective. It will take years, however, to begin reaping these financial rewards. Thus, in the interim we must identify additional financing sources. AMWA applauds H.R. 1200's \$2 per pack excise tax on cigarettes as one of these funding mechanisms. AMWA has long been outspoken in recognizing the excise tax as one of the most effective tools for raising revenue, as well as saving lives by deterring tobacco use, especially among children.

Conclusion

The American Medical Women's Association welcomes this subcommittee's scrutiny of the current obstacles facing physicians and patients in today's health care system. The single-payer proposal, though dramatic and even daunting in its scope, offers an exceptional prescription for change. AMWA looks forward to helping enact H.R. 1200's principles for comprehensive, universal reform. Thank you.

Mr. WAXMAN. Thank you very much. I would like to thank the four of you for your testimony. I think it is very helpful for us to have your comments on the record of this subcommittee.

Dr. Anderson, one of the arguments that people make frequently against the single payer system is that the bill, according to CBO estimates, in the first full year of operation will cost the Federal Government over \$500 billion. Putting this additional amount on the Federal budget each year is a particularly sensitive subject in today's political climate.

However, I think a lot of people lose sight of, or choose to ignore, the fact that for the most part these are payments that are in place now in the form of employer and worker premiums for existing health benefits. It is essential in understanding that H.R. 1200 to compare the estimated payments for health coverage that business and employees are going to face if we do nothing with the estimated payments that they are going to have to pay under H.R. 1200.

Your testimony has been extremely helpful in showing how the bill would affect different Americans in different circumstances. You talked about the fact that 75 percent of Americans who are currently insured will pay less for their premiums. Tell us about that 25 percent who are currently insured who will pay more and how much more do you estimate they will have to pay?

Mr. ANDERSON. It is essentially the individuals who are in higher incomes and especially those people who earn their income through stocks and bonds. They are the ones who are effectively going to be paying higher amounts for health care than they currently do. It is really dependent upon their level of income, how much more they will, in fact, pay.

This proposal will effectively help lower income individuals; it will help people with current chronic illness who have trouble getting health insurance; and it will help individuals who are in small firms who cannot purchase health insurance or when they try to purchase health insurance they have to pay in a high premium currently.

Mr. WAXMAN. How about for the middle-class, people who are working now in the great industries of this country who have pretty good insurance, are they going to pay more for less?

Mr. ANDERSON. They will get more. It is a much more comprehensive package than most everybody has now. So they will certainly get more.

I took a look from the Employee Benefits Research Institute data on a variety of employers, a variety of firm sizes, and for most employers, for most firm sizes, people will in fact pay less under this legislation. It clearly varies depending on how much of a deal you are getting, how healthy your people are in your particular company. But for the average American person right now earning between \$20,000 and \$50,000, virtually all of them will pay less under this legislation than they are currently paying.

Mr. WAXMAN. Thank you very much.

Dr. Freedman, your colleagues in the American Medical Women's Association don't share your enthusiasm for this legislation. On the next panel they will testify that H.R. 1200 does not reward excellent provider performance and lacks incentives for innovation. You,

on the other hand, testified that H.R. 1200 offers a definitive mechanism for tracking outcomes data and adapting to emerging health care trends.

I am sure we could all agree that we want to reward excellent performance and innovation on the part of physicians. The AMA seems to think this bill won't do that. I take it from your statement that have you no problem with the bill in that respect. Can you help us understand how you have arrived at such a different conclusion than your medical colleagues?

Ms. FREEDMAN. To try to address those, we reward physician's skills in a number of ways and financially is one. I think that those days are over and that is not how we should be rewarding physicians.

When we look across the world at other countries with single payer plans, excellent physicians are rewarded by their position, be it at a medical school, university hospital, by their standing in the community as far as their patients think of them, how they patients refer their friends to them and how their colleagues refer their patients to each other among physicians. The actual method by which a health care system is funded is an independent system and how physicians are rewarded for their excellent skills.

We should not be reward financially for providing good care for our patients. We should be rewarded by receiving the respect of our colleagues and of our patients. And I really don't see that a single payer plan at all interferes with that.

Mr. WAXMAN. Thank you very much.

Ms. FREEDMAN. Remind me of the other half of your question.

Mr. WAXMAN. No, that was good. I think you answered the question.

Mr. Franks.

Mr. FRANKS. Thank you, Mr. Chairman.

In my prior life I worked in the human resources field and I handled health care benefits for two Fortune 500-type companies, and I also worked for a British company that had a Canadian division, And many people who worked in Canada. They traveled to Toronto and Buffalo to get health care. My question to you would be what does that tell you about the Canadian single payer system? And does that concern you as far as the question of quality of care?

Ms. NICHOLS. Well, actually, the number of people flowing over the border to use the American health care system is greatly exaggerated. Certainly people do come to this country in order to seek care, but one of the biggest strain on the Canadian health care system right now is actually fraudulent use of the Canadian health care system by Americans in order to get coverage up in Canada. So there is a reverse trend on the border going northward in order to get care. The Canadian health care system has excellent care.

There are many kinds of procedures and facilities they have there that we don't have here and vice versa. So at times there will be traffic across the border to take advantage of those different types of things. An example of that is Senator Paul Tsongas who actually was not a proponent of the Canadian health care system and decried its health care system, actually got his bone marrow transplants in the Toronto hospital because they have one of the

greatest bone marrow procedures in the world. So there is a lot of innovation on both sides of the border.

Ms. KAZDIN. Mr. Franks, I am with the Amalgamated Clothing and Textile Workers Union and we have members both in Canada and in the United States. And without question, our members in Canada are far more satisfied with their health coverage than are our members in the United States, even though we provide fairly decent coverage for our members in the United States. We don't have members that come from Canada down into the United States to get care at all. They feel that they are much better cared for up there.

Mr. FRANKS. I would contend that. I was in charge of human resources for a company in the USA, and had a counterpart who was in charge of the same for Canada and a number of people went to Detroit from Toronto to get health care coverage. A number of problems came up. Depending on your ailment, the prospects of your receiving immediate health care treatment would be delayed. I had a story where a person who used to work for our company had a bad knee and he kept on putting off—he worked in Canada—he kept on putting off the surgery because he was on a certain list that prevented him from being able to have treatment for that knee a lot earlier. And he developed a bad back right after he had a bad knee.

So I have a number of anecdotes from people that I actually worked with, granted it was during the early eighties and mid-1980s, but I would hope that things have improved with their system. But I think that some of the basic components of their system would still create a situation where people would travel to Toronto, to Detroit or some to the United States, and we have all heard of those stories. The stories that you have mentioned are very few and far between.

Ms. KAZDIN. I would contend with two points on that. One is that the technology in the United States, we in contrast with Canada have overcapacity relative to what Canada has in terms of a lot of these high-tech machines that dominate the medical profession. You can find anecdotal stories of people who crossed the border to take advantage of the high-tech that we have here that perhaps they don't have as developed in Canada.

The second point that I would make is that if you talk about people being able to get care, and you contrast the system here in the United States with that in Canada, low wage workers and unemployed people and people who live in rural areas do not have access to health care, period, in a lot of instances in our country.

We have members in the rural south who have to travel for 3 hours to get to any kind of medical care at all. So—

Ms. NICHOLS. I just needed to add, if I may, that we do spend nearly 30 percent more per person in this country on health care than they do in Canada and the American Health Security Act continued to assume a high level of funding, which means that to the extent that there are waiting lists for non-urgent care in Canada, we should be able to eliminate that possibility here. And the insurance industry has never spent one thin dime on research and development. It is our Federal Government, in large part, which

causes the high levels of technological superiority here and we want to see that go under a single payer system.

Mr. FRANKS. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Moorhead?

Mr. MOORHEAD. You know, one of the things that has gotten a lot of publicity in our country is about the shortage of funds they have up in Canada. It started out that the provinces were financing the health care program to begin and the Federal Government came in later with 50 percent and then they have had to cut back. So a lot of the provinces are having a very, very difficult time keeping up financially. And it was well publicized that during the last few weeks of the year they had to shut down all the hospitals, except for dire emergencies, because they didn't have the money to take care of people.

I don't want what quality of health care you can get under those circumstances.

Ms. FREEDMAN. I would like to respond to that. We don't have to copy the Canadian system word for word and period for period. And it has been pointed out that the Canadian system probably is to some degree underfunded right now.

Canada is in a recession deeper than ours. They have a higher rate of unemployment and as a result, as Dr. McDermott described before, they lump all of their funding together. So if they are falling short in road construction, they can take money out of health care for that.

Well, this bill does not allow for that. In addition, we have to remember, we have waiting lists in this country right now. And the hospital that I work at rarely performs elective surgery on schedule because of those waiting lists and our patients wait months and months for elective surgery. So we are rationing here by economic class, by inconvenience, by geography rather than looking at our overall system and saying what level of care do we wish to provide to our Nation.

Mr. MOORHEAD. What kind of insurance or health care does your firm have?

Ms. FREEDMAN. I am a physician. I work for a public hospital in New York City, one of the few cities that has an extensive public hospital, which takes care of patients who are primarily covered by Medicaid/Medicare without secondary coverage or by their own pockets; they have no private insurance, by and large. Many of my patients once had private insurance and lost it due to illness, pre-existing condition or unemployment and they are waiting for health care routinely days, months, or years.

Mr. MOORHEAD. The people that are unable to pay for their services themselves and don't have insurance?

Ms. FREEDMAN. The people who have insurance that is not accepted by most private hospitals because it doesn't have adequate payment such as Medicaid; people who have Medicare but don't have medigap insurance or people that have no coverage or coverage with high deductibles and they come to the public hospital system where we do our best, but we don't have the ability to provide the care that they need.

Mr. MOORHEAD. I know that in the Los Angeles County Hospital, which I had occasion to visit not long ago, and UCLA and USC

Medical Center, which is right next to the county hospitals, they have the best doctors that you can find any place that service those institutions and while you sometimes have to wait for a bed, there doesn't seem to be any delay in the operations once they can get a bed there.

Ms. FREEDMAN. I am sure there is not delay in emergency services but I am sure there is delay in elective services as well as in receiving primary care. My hospital really is quite similar—I know the L.A. County hospitals and the Cook County hospitals and the public hospitals in Detroit, Atlanta and Miami, we all share the same problems of underfunding and we are unable to provide primary care and elective joint replacement surgery in any way that would be acceptable to people that had private insurance and expected care when needed so we are rationing care, just in a different manner than Canada or other countries choose to do it.

Mr. MOORHEAD. Our committee had occasion to visit England, France, and Germany last year, looking into their medical system. In England we asked them about their long delays in other than emergency care. And we asked them why, because it is obviously not going to cost any more to operate on them a year from now than it would to operate on them today.

They responded that some of those people would die in the meanwhile, they wouldn't have to do it; and some of the people would move away or be gone, and others would change their mind about the operation, so that they wouldn't have to do as many, and that is why it would cost them less money. I don't think anyone wants to get into that kind of a situation where a hip replacement can make them employable, where they are not employable otherwise.

I saw a girl—a young woman who had been operated on her eyes. She had never been able to see more than a few inches in front of her—at USC Medical Center that had her eyesight restored to 12/15 by the able doctors there. But those people were put off forever; instead of having useful lives, you get that kind of delays. And I don't think any of us want a system where you can't get taken care of fairly soon upon the availability of care.

Ms. FREEDMAN. I think we certainly all agree with that, that care should be delivered when it is needed. Delays and waiting lists are a reflection of undercapacity, and Britain has an undercapacity of services. There is no doubt about it. That is one way they choose to hold down costs.

Our health care system, as you have heard already, spends 30 percent more than any other country per capita on health care. We have the money in the system. We are just spending it in the wrong place. We are spending it on denying care, which is one of the areas where a lot of the pre-certification and administrative hurdles are. They are to deny care for patients. And we hide it in the guise of administration so our patients don't even often know it is happening. It is denial.

Mr. MOORHEAD. Paperwork and defensive medicine and many other things. Because of the malpractice situation, a lot of those things can be corrected without changing the system. You can change some of the basic laws. You can take care of a lot of that.

Mr. WAXMAN. Mr. Moorhead's time is expired. To be fair, we are going to have to move on.

Mr. Kreidler, did you have any questions at this time?

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Freedman, since we are following up on the English system, maybe—perhaps you are an expert on this, so I will ask you the same question. I don't know that you are.

Ms. FREEDMAN. The British system is not a single-payer system as this H.R. 1200 describes.

Mr. KREIDLER. I agree.

And one of the points you did touch on is the level of funding that did take place in health care services. We are at \$1 trillion, as you pointed out. You said 30 percent more per capita. Someone said 40. I guess it depends on which numbers we use.

Given a comparison between, let's say, the English funding and the American, I would think that the differences, rather than 30 or 40 percent, would be considerably higher. So a comparison with H.R. 1200 or any of the health care reform proposals, whether it be the President's or others, I think would be inappropriate if it is going to be looking at what might be alluded to as some form of rationing.

Perhaps you would care to comment on the ability of the system to not have that kind of problem. How would the English system—perhaps if they had an infusion of something close to the level of funding we have right now in the United States, do you think their problems with inadequate capacity in the system would be resolved rather handily or not?

Ms. FREEDMAN. I don't really think I am prepared to address the deficiencies of the English system and whether infusing money would help. I am personally more familiar with the Canadian system, and it is a system that—

Mr. KREIDLER. Which spends money at a much higher level than they do in the English system.

Ms. FREEDMAN. Yes, a much higher level.

Mr. KREIDLER. Second only to the United States, if I am not mistaken, per capita.

Ms. FREEDMAN. Yes. And I think that they—they make choices of where to put both capital expenditure and personnel expenditure and review those choices roughly annually.

Some of the shortfalls we see, for example, in Ontario is really reflective of the dramatic financial crisis that Ontario is currently undergoing which they did not have 10 years ago or 15 years ago, when the system did not have some of the problems we are seeing now.

Ms. NICHOLS. Could I just add briefly about Ontario? There was a big report in The New York Times not too long ago about cutbacks in Ontario. Actually, those were proposed cutbacks, not actual cutbacks, and the only cutback that actually got enacted was removing electrolysis from the list of covered procedures. So that is a gross distortion of what was happening in Ontario. And a lot of people, I think, read that article and have been depending on it.

The other thing I think is very important to state is that in Britain the hospitals are owned and operated by the government. The doctors work for the government. It is a government-run system. In Canada, it is merely government financed. I know you know this, Mr. Kreidler, but just to point this out to everyone. It is a gov-

ernment-financed system and so very different in the way in which it operates.

Mr. ANDERSON. At Johns Hopkins we are taking a look at our cataract surgery. This major elective procedure is done in a variety of countries including Canada and the United States. And, basically, what we are seeing is very few Canadians want to come to the United States to have their cataract surgery. They are not willing to pay the additional money. They recognized that there is a wait, but, at the same time, when there is a wait for it and somebody has an emergency, either because it interferes with their work or it would interfere with their health, they are bumped up in front of the queue, and they receive surgery almost immediately. It is people who can wait who do it.

If we look at the United States in east Baltimore where Johns Hopkins is one of the best if not the best place to have cataract surgery in the United States, the major reason for blindness among the elderly in the east Baltimore area is untreated cataracts, and so we are not getting the care in the United States. That, in a sense, is rationed care in the United States.

Mr. KREIDLER. That is a good point, very apropos for an optometrist to hear that, too.

One of the questions about H.R. 1200 has been about the method of delivery. Would it be based on something close to what they have in Canada or would it be, in fact, based on something more akin to the American system where we see much of the care delivered through plans, albeit much of it done through indemnity plans? But would it effectively involve the evolution toward managed-care plans being the primary mode of delivery through H.R. 1200 or a single-payer plan as presently construed? Would somebody want to respond to that?

Ms. NICHOLS. H.R. 1200 actually allows managed-care plans to exist and somewhat encourages their development actually more than we would like to see. We don't think managed care saves money, and we don't think we should go in that direction, but people—managed care, whether it would nourish or not under the American Health Security Act, would depend on whether people chose it. They have a card, and they can go to a doctor, privately in a fee-for-services system or managed care on the basis of quality rather than just cost. And if people continue to go to managed care, then it would flourish.

If they wanted to go to independent doctors, they would flourish. It would depend on which was providing the best service to the consumer and not on whether they were reducing care to save costs.

Mr. KREIDLER. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Kreidler. My thanks again to this panel. You have given us excellent testimony. Thank you.

Our last panel of witnesses this morning consists of individuals representing organizations that are opposed to H.R. 1200: Dr. Lonnie R. Bristow is chair of the board of trustees of the American Medical Association; Chip Kahn is the executive vice president of the Health Insurance Association of America; and Paul Huard is the senior vice president for policy and communications of the National Association of Manufacturers.

I want to welcome you to our subcommittee. Your prepared statements will be placed in the record in full. What we would like to ask you to do is limit the oral presentations to no more than 5 minutes.

Dr. Bristow, why don't we start with you?

STATEMENTS OF LONNIE R. BRISTOW, CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; CHARLES N. KAHN, III, EXECUTIVE VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; AND PAUL HUARD, SENIOR VICE PRESIDENT, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. BRISTOW. Thank you, Mr. Chairman and members of the subcommittee.

Good morning. My name is Lonnie R. Bristow, M.D. I am pleased to be here today as a physician and as the chairman of the board of the American Medical Association.

I want to stress at the beginning that the AMA wholly shares in Representative McDermott's plan for universal coverage for all Americans. It is the AMA health system reform priority, too, and we agree with Representative McDermott that the status quo is not acceptable. The 37 million Americans who are uninsured and many of our low-income patients who are continually barred from comprehensive health care coverage need help.

Mr. Chairman, last week the AMA announced a new proposal for action called Providing Health Coverage for All Americans. This proposal is attached to the written statement, and it reaffirms the commitment to universal coverage that we announced 4 years ago in our health system reform plan, Health Access America. We are gratified that the President and Congress, indeed, the Nation and—now they recognize the need for action, and we pledge to work with you to achieve the goal of universal coverage.

Our view of how universal coverage should be achieved, however, differs from that of H.R. 1200. The AMA believes that a private, market-based health care system that builds on and improves our existing employer-based system is the most realistic and cost-effective way to achieve universal coverage and at the same time preserve quality and slow the rate of growth in health spending.

We support a variety of approaches for financing our goal of universal coverage for all Americans. Those approaches include an employer mandate, an individual mandate and the use of medical savings accounts. A flexible multifaceted approach will work best in America, a Nation that combines a high degree of technology with an extremely diverse population covering a very large geographic area.

We are concerned that a single-payer system would also be less responsive to patient needs, neglect capital structure demand and technological advances. It would reduce incentives for excellent performance and innovation and result in backlogs.

Government should help ensure that the private sector operates fairly. It should not supplant what the private sector has accomplished and can continue to offer in providing high-quality health care.

We appreciate the protections H.R. 1200 offers for fee-for-service medicine, patient choice and physician clinical autonomy. Patients want physicians to work as their advocates, not under the shadow of a health plan that has a financial conflict of interest with providing quality patient care.

Patient and physician experiences with government-sponsored health care in Canada and Great Britain indicate that costs rather than quality too often dictate treatment decisions. The AMA, therefore, cannot support strict global budgets and price controls to programs that hold patients' lives and welfare in the balance. We support an approach that would slow the rate of growth in health spending by increasing competition, encourage cost conscious patient decisionmaking and require employers and insurers to offer individuals a choice of health plans and financing mechanisms.

Our vision also supports a negotiated goals' approach in which physicians would sit down at the table with State or Federal representatives to establish reasonable spending targets that account for demographics, disease, technology and demand factors.

Many of the AMA reform goals mirror those of H.R. 1200. Both support achieving universal coverage, administrative simplification, a standard benefits package which underscores preventive care, cost-sharing and the use of taxes on lethal products like tobacco, handguns and ammunition.

Physicians, however, not accountants, must make medical-care decisions. And any health system reform plan must contain substantial antitrust reforms, including legislation to allow the formation of physician-sponsored health care delivery networks and plans, additional safe harbors for physician groups to form competing health plans and physician direction of standards for practice parameters, outcomes research and other quality assurance protocols.

We also advocate liability reforms such as those in my own State of California enacted in 1974 under MICRA. Since MICRA's enactment, liability insurance premiums in California have increased only modestly to being now about 40 percent lower than New York premiums, with even greater differentials for certain specialties.

In conclusion, Mr. Chairman, the AMA strongly urges that any health system reform plan must be based on, one, universal coverage for all Americans with a standard package of benefits; two, a private public system that creates competitive forces to restrain health care costs; three, insurance reform, including guaranteed portability; and, four, affirmation of the physician's role as patient advocate.

Although our means may differ from H.R. 1200, we are both committed to universal coverage, and we look forward to working with you to reach that goal.

Thank you, Mr. Chairman.

Mr. WAXMAN. I thank you very much, Dr. Bristow.

[Testimony resumes on p. 657.]

[The prepared statement of Mr. Bristow follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health and the Environment
Energy and Commerce Committee
of the
U.S. House of Representatives
Presented by
Lonnie R. Bristow, MD
RE: H.R. 1200, the "American Health Security Act of 1993"
February 1, 1994

Mr. Chairman and the Members of the Subcommittee:

My name is Lonnie R. Bristow, MD. I specialize in the practice of internal medicine and also serve as Chairman of the Board of Trustees of the American Medical Association. Accompanying me is Carol O'Brien, JD, of the AMA's Division of Federal Legislation. I appreciate the opportunity to present the AMA's vision of health system reform and our comments on H.R. 1200, the "American Health Security Act of 1993." The bill was introduced this past year by a physician colleague -- Dr. Jim McDermott -- who also serves as a U.S. Representative from the State of Washington. The AMA Board of Trustees had the pleasure of meeting with Dr. McDermott several months ago to discuss H.R. 1200 and we were impressed with his candor and his commitment. We are pleased to be able to tell you that we share his commitment.

The AMA has not endorsed H.R. 1200, nor any legislative proposal introduced in the 103rd Congress, but we are looking for common ground. We are continuing to review various proposals and analyze them as refinements are made. However, we support many aspects of various proposals as consistent with the health system reform vision and proposal for action, Providing Health Coverage for All Americans, that we announced last week. A copy of this proposal is attached to our statement. The AMA first called for comprehensive health system reform four years ago in Health Access America, the AMA's plan for health system reform and universal coverage for all Americans. The nation is still waiting for action.

We commend the efforts exemplified by Representative McDermott in H.R. 1200 to remedy inequities in the current health care system. We agree that barriers to care are intolerable, especially the lack of health coverage that adversely affects many low-income patients, the 37 million uninsured, and according to the U.S. Census Bureau's Survey of Income and Program Participation studies, the 32.1 million patients who in 1990 lacked insurance in any given month.

We strongly agree with the premise of H.R. 1200 that the status quo is not acceptable and that the time for action is now. Universal coverage for all Americans under a standard set of health care benefits, regardless of employment or economic status, is the sine qua non of any acceptable health system reform plan. Additionally, as H.R. 1200 recognizes, funds to ensure adequate coverage of undocumented aliens must also be included in a reform plan. As the nation's largest physician organization, patient health and access to care through universal coverage is our number one health system reform priority. Ultimately, health system reform will not succeed unless all Americans are guaranteed coverage.

Accordingly, we strongly support the goal of H.R. 1200 to attain universal coverage. However, while we share this common purpose of providing affordable and complete health care coverage to all Americans, the means we support to achieve this end are different. The AMA believes that a private, market-based health care system, which builds upon and improves our existing structure, presents the best and most realistic approach to achieve universal coverage, safeguard quality of care, and slow the rate of growth in health spending.

As we recently announced in our new proposal for action, the AMA supports a variety of approaches to achieve universal coverage, including an employer mandate, an individual mandate, and health IRAs or medical savings accounts (MSAs). While the AMA continues to support a requirement for employers to contribute to the financing of health care coverage for their employees, we also believe other means of achieving universal coverage should be considered. Flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage for all Americans.

We believe an adaptable, multi-faceted approach is the most complete and cost-effective way to achieve universal coverage in the U.S. -- a country that uniquely combines the characteristics of being a technologically advanced nation, with an extremely diverse population, within large geographic boundaries. H.R. 1200 is based on a Canadian-style single payor model. The AMA supports continued study of this model. However, we believe this system is less responsive to patient needs, neglects capital structure demands and advances in technology, does not reward excellent provider performance, lacks incentives for innovation, (such as the free-standing emergency and outpatient surgical centers and HMOs that in recent years have provided more access to more affordable care to many,) and, most significantly, results in backlogs, delayed access to treatment, and disincentives to

provide quality care. Government should help ensure that the private sector operates fairly, but it should not be allowed to supplant what the private sector has accomplished and can continue to accomplish in providing Americans with high quality health care.

As patient advocates who believe the patient-physician relationship must supersede cost considerations, we have struggled philosophically with whether a single payor system, such as that envisioned by H.R. 1200, would be preferable to the managed competition models of proposals like President Clinton's H.R. 3600. Lacking a crystal ball, our position -- based on experience, studies, and logic -- is that a private health care system, rather than a single payor system, but with essential insurance, small market, and other reforms, will best preserve patient quality of care.

The AMA appreciates the fact that H.R. 1200 would preserve fee-for-service medicine as an essential choice available to patients. Another underlying principle of H.R. 1200 that the AMA also strongly supports is the implicit recognition that preserving patient choice and physician clinical autonomy will help facilitate necessary access within the context of universal coverage. Meaningful choice will not be realized, however, if patients under a health system reform plan are limited to low-end managed care plans that determine or limit patients' choice of physician, reduce access to specialist care, and diminish quality by cutting corners.

The AMA supports H.R. 1200's provision that any physician who meets state requirements and basic national standards would be considered a qualified provider. We believe the system and patients will be best served if patients have a meaningful choice in care. As the President emphasized in his State of the Union address, patients want to choose their own physicians and to change doctors if dissatisfied. They want personalized service, and stability and continuity in physician-patient

relationships. Patients want to be able to choose whether or not to join a plan that limits their choice of physician. They want a physician to work as their advocate, not under the shadow of a health plan which has a financial conflict of interest with providing patient care. Accordingly, we support H.R. 1200 for establishing an environment where patient choice will not be diminished.

Even given our support for patient choice and inclusion of fee-for-service plans under H.R. 1200, we have serious concerns that if physicians and plans are forced to provide care under strict global budgets, patients and quality of care would suffer. As physicians, we agonize over the care dilemmas that we see will be posed in a new world of global budgets. We are concerned that if certain of the health care reform plans become reality that most of our female patients in their 30s or 40s would be denied coverage for mammograms as not "cost effective" for that age group, even though thousands of young women are diagnosed annually with breast cancer. Similarly, physician and patient experiences with government-sponsored health care in Canada and Great Britain indicate that cost, rather than quality, too often dictates treatment decisions.

While quality and patient needs must be our priorities, the AMA also recognizes that rising health care costs must be stemmed. The Congressional Budget Office projects that the plan's projected cap on total health care spending would save 6% of the nation's health bill by 2003, while providing universal coverage. While such projected savings support an argument for tighter budget management, the AMA cannot support the application of uncompromising global budgets and price controls to systems and programs that hold patient lives and welfare in the balance. Instead, we support an alternative approach that would slow the rate of growth in health care spending by increasing competition in the marketplace, encouraging cost-conscious patient decision-making, and requiring employers and insurers to offer individuals a choice of health plans and financing

products and a 50% excise tax on handguns and ammunition. This public health measure is long overdue, and will help to discourage the destructive behaviors caused by these lethal products.

Despite the AMA's lack of support for a single payor approach to accomplish health system reform,

the AMA shares Rep. McDermott's commitment to **assure universal coverage for all Americans**.

We support a variety of funding approaches rather than a single payor, government-run plan to achieve this goal. Additionally, we support, and will work hard to accomplish insurance market reform. Our most critical goals for insurance reform are to implement community rating, so that health insurance coverage is affordable, especially for small employers, small groups of employees, and individuals; to eliminate pre-existing condition limits that leave individuals with chronic health problems without coverage for some period of time and create job lock; and ERISA reform to assure that beneficiaries of self-insured plans have access to a standard benefits package and are not subject to unfair or discriminatory coverage decisions.

The AMA also believes that physicians must become more involved in the emerging health care system to assure strong patient advocacy and clinical autonomy. Physicians -- not accountants or bureaucrats -- must make medical care decisions. Accordingly, we will work to ensure that any health system reform plan includes the following:

- Legislation that facilitates the formation of physician-sponsored/directed health care delivery networks and health plans.
- Reform of antitrust laws to allow for safe harbors similar to those developed by the Department of Justice and Fair Trade Commission, but expanded to allow the formation of physician groups representing up to 35% of the physicians in a market in exclusive networks.

mechanisms. To reasonably be able to forecast health care spending, our vision for reform supports a negotiated goals approach that would involve physicians in establishing reasonable health care spending targets that take into account demographics, disease, technology and demand factors. If targets are not met, physicians and other professionals should be able to examine the causes of rising costs, and make reasonable adjustments that would not adversely affect patient health or access to care.

Accordingly, we must oppose the strict budgeting aspects of H.R. 1200, including its price controls on pharmaceuticals, equipment and setting of prospective fee schedules. Price controls have never worked; rather, in countries where such controls have been imposed, patients endure waits of months or years for surgery, are denied access to specialists, and face other obstacles to care. Any health care system predicated predominantly on cost containment will contain perverse incentives that will undermine quality and the physician's duty to act in the best interest of his or her patients.

The plan offers other features, however, that we strongly support as consistent with our own vision. We support H.R. 1200's proposal for administrative simplification and universal claims processing. The AMA strongly endorses H.R. 1200's inclusion of a generous benefits package, which reinforces preventive care and closely tracks our own AMA standard benefits package. Similarly, we back H.R. 1200's cost-sharing provisions as promoting patient awareness of costs and responsibility. We do, however, have reservations that the plan's overall funding scheme, premised on broad-based employer and employee taxes, will insulate individuals from actual health care costs and lead to disincentives for cost containment and inappropriate utilization of services. While we support the use of broad-based taxes, rather than reductions in Medicare and Medicaid, to contribute to universal coverage if necessary, we do not endorse a single payor, completely government-driven mechanism to accomplish that. We do strongly support H.R. 1200's inclusion of a \$2.00 per pack excise tax on tobacco

and 50% in nonexclusive networks, with percentages adjusted upward for rural areas.

- Legislation to direct non-physician sponsored health plans to create committees, similar to a hospital medical staff, or practicing physicians in the plan to provide input about coverage, medical review criteria for individual coverage decisions and credentialing of physicians, administrative procedures, physician payment, and other matters.
- Establishment of negotiated rule-making, backed by binding arbitration for dispute resolution, as the primary method for developing federal health care regulations, with the AMA acting as the profession's lead negotiator.
- Standard setting to be performed by physician organizations in such areas as the development of practice guidelines, outcomes measurement and reporting, and performance standards.

Any health system reform plan must contain antitrust relief that will allow physicians to negotiate in good faith to offer health care services to insurers or patients, and to place physicians in the same position as corporations to direct health networks. A balance between the increasing dominance of corporate cost-cutting medicine and patient advocacy must be struck.

H.R. 1200 is silent on the issue of professional liability reform. Yet, defensive medicine significantly drives up health care costs. A study by Lewin/ICF found that the cost of defensive medicine activities totaled \$25 billion in 1991. Major liability reforms, such as California enacted in 1974 under the Medical Injury Compensation Reform Act (MICRA), have proved successful in reducing liability insurance premiums. Prior to California's reforms, physician professional liability premiums were roughly equivalent to New York's. Today, the average New York physician's liability premiums are about 40% higher than in California, with differentials of up to three to five times in some specialties, such as obstetrics and neurosurgery. The California experience illustrates that professional liability

reform must be enacted to stem the significant and unnecessary costs related to liability.

Accordingly, the AMA supports liability reform provisions that include a \$250,000 cap on non-economic damages; mandatory periodic payment of future elements of damages; mandatory offset of collateral sources, a sliding scale limit on attorneys' fees, related to award size, a determination of merit prior to filing medical liability cases, and the ability to use accepted practice parameters as an affirmative defense.

The AMA advocates that any compromise health system reform plan must be premised on: 1) universal coverage offering a standard set of health benefits; 2) a private/public system that creates competitive forces to constrain rising health care costs; 3) insurance reform, including guaranteed portability of coverage and underwriting restrictions, and 4) affirmation of the physician's role as patient advocate. Like the sponsors of H.R. 1200, we also support measures to cut administrative waste, improve coverage for lower income individuals, and establish protocols and oversight for quality assurance. Although our means differ, the AMA and the sponsors of H.R. 1200 are committed to assuring universal access and coverage. We look forward to working with you this year to reach that mutual ground.

(Following is the text of the AMA Proposal for Health System Reform that is being distributed to Congress, other policy-makers, and the media.)

January 1994

**American Medical Association
"Providing Health Coverage for All Americans"
Health System Reform Proposal for Action**

In 1990, the American Medical Association (AMA) called for comprehensive health system reform in its proposal, "Health Access America". We're still waiting for action. Many Americans are still shut out of our health care system; millions of others face the problem of staying in a job simply because it offers decent health insurance; others are financially ruined because of devastating health care expenses. Changes in the marketplace are also jeopardizing patients' freedom to reach health care decisions with their physicians and replacing physicians' clinical judgment and decision-making expertise with corporate cost-cutting concerns.

To remedy these problems, the AMA urges Congress to pass a health system reform bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We present this current reform proposal to accelerate legislative debate and action. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Our proposal also recommends a significant role for physicians as patient advocates in shaping policy, health care payment and delivery decisions under a revamped health system. If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care. In managed care and other delivery arrangements, patient-physician decisions must prevail over economic considerations.

The AMA reform proposal is intended to:

- Achieve universal health care coverage for all Americans;
- Strengthen the voice of physicians in clinical judgment and decision-making to balance the ever-increasing corporate domination of health care;
- Promote compromise and flexibility to achieve universal coverage and to design the best approach to shared responsibility of employers, individuals, and government in paying for health care coverage;
- Slow the rate of growth in health spending through competition in the marketplace;
- Effect major professional liability reform to reduce the inappropriate cost of defensive medicine and liability insurance premiums;
- Assure that all Americans have choice of health plans and physicians;
- Provide individuals with price and quality information to make informed health care decisions; and

- Create a more efficient, streamlined, and coordinated health care system.

Our proposal recommends the following fundamental changes to our health care system.

Universal Coverage

Health care coverage must be extended to all Americans. We support a variety of approaches to achieve this goal: an employer mandate, an individual mandate, and health IRAs. As the congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage with a standard set of health care benefits for all Americans.

Insurance Market Reform

To ensure that insurance carriers can no longer deny coverage to individuals with chronic or other medical problems, or refuse to renew such coverage -- and to even out the affordability of health insurance premiums -- the following insurance market reforms are essential:

- Implement community rating; and
- Eliminate pre-existing condition limitations so individuals with chronic or other medical problems can secure and keep private health insurance.

Health Insurance Purchasing Cooperatives

- The insurance market reforms we advocate are similar to those that have worked successfully in Hawaii; specifically community rating, elimination of pre-existing condition clauses, and portability of coverage. To the extent these reforms are adopted -- particularly community rating which would make insurance available to all at no more than a community-established premium -- then health insurance purchasing cooperatives would serve primarily to disseminate information to the public. Without such insurance market reforms, voluntary private sector health insurance purchasing cooperatives are desirable so that small firms and individuals can benefit from the market power of group purchasing. Under such a purchasing cooperative approach, competing cooperatives in the same geographic region are essential to ensure that no one giant purchasing conglomerate could monopolize the market, thereby reducing competition and consumer control of health care decisions.

Physician Involvement in The Health Care System

Antitrust Relief
Physician-Directed Networks
Negotiated Rulemaking
Self Regulation

Today's health care marketplace is increasingly characterized by corporate, and often for-profit, organizations and large managed care plans that are taking aggressive action to control the delivery of health care services and reduce their costs. While efforts to save costs are appropriate and desirable, excessive concern for costs can interfere with the availability and delivery of health services to patients and diminish the quality of those services.

If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care to balance the ever-increasing corporate domination of health care.

Under the current antitrust laws, however, physicians who engage in negotiations are threatened with criminal prosecution or costly civil litigation. This state of affairs is simply unacceptable as a matter of health care policy and fundamental fairness. To correct this situation and to foster meaningful reform whereby treatment decisions are made on the basis of what is best for the patient -- not what is best for the corporate bottom line -- we propose the following:

- Enact legislation that facilitates the formation of physician sponsored/directed health care delivery networks and health plans. This legislation should authorize physicians to form these entities and provide exemptions from regulations that interfere with this activity.
- Reform the antitrust laws to allow for safe harbors similar to those developed by the Department of Justice and Federal Trade Commission, but expand the safe harbors for the formation of physician groups representing up to 35% of the physicians in a market in exclusive networks, and 50% in nonexclusive networks. Such percentages may need to be adjusted upward in rural areas.
- Enact legislation to direct non-physician sponsored health plans to create committees, similar to a hospital medical staff, of practicing physicians in the plan to provide input about coverage, medical review criteria for individual coverage decisions and credentialing of physicians, administrative procedures, physician payment, and other matters. The legislation would recognize the right of physicians to make presentations to health plans that has been provided for in federal judicial decisions.
- Legislation also should be established under federal law for negotiated rulemaking, backed up by binding arbitration for dispute resolution, as the primary method for developing federal health care regulations, with the AMA acting as the profession's lead negotiator. Such mechanisms would not establish -- nor would it be to the benefit of patients or physicians to establish -- any "right to strike" by physicians.
- Standard setting should be performed by physician organizations in such areas as the development of practice guidelines, outcomes measurement and reporting, and performance standards. The development and application of standards for medicine is an area where the profession has excelled, particularly in the accreditation of medical education and health care institutions. This method is highly effective on a performance and cost basis. As part of this, medical societies should be allowed to conduct medical peer review activities and mediate fee disputes between patients and physicians for purposes of professional self regulation and discipline.

Professional Liability Reform

Defensive medicine, the ordering of tests and procedures which might not be ordered were it not for liability concerns, drives up health care costs. Liability insurance premiums and defensive medicine activities add significantly to the average physician's bill for services. According to Lewin/ICF, the cost

of defensive medicine activities performed by physicians totaled \$25 billion in 1991. These unnecessary costs are passed on to patients and contribute to rising health care spending.

Major liability reforms -- similar to those enacted in California in 1974 -- must be enacted to control these costs. California's experience has proven that such reforms significantly reduce physician's liability insurance premiums. Prior to enactment of California's liability reforms, physician's professional liability premiums were roughly equivalent in California and New York. Today, physician's average liability premiums are about 40 percent higher in New York than in California, with differentials of up to three to five times in some specialties (such as obstetrics and neurosurgery).

Our proposal specifically recommends:

- A \$250,000 cap on noneconomic damages;
- Mandatory periodic payment of future elements of damages;
- A mandatory offset of collateral sources, such as health insurance and disability benefits when computing compensation to prevent double recovery of damages;
- A sliding scale limit on attorneys' fees in relation to the size of the award;
- A statute of limitations, applicable to adults and minors, to limit the time period for filing claims;
- A certificate of merit as a prelude to filing medical liability cases and adopting basic criteria for medical expert witnesses;
- Encouragement of patient safety issues as an integral component of outcome and quality assessment programs; and
- Providers following clinically relevant practice parameters developed by professional associations should be allowed to raise such compliance as an affirmative defense in liability actions.

Quality of Care

The quality of health care in the United States remains unsurpassed -- and is one of the greatest strengths of the American health care system. To ensure this continued level of excellence, physicians and their professional organizations should continue to control the standards for quality care delivered to patients. Such standards will help to assure that only appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care.

Our approach presents a public/private partnership to enhance quality, rather than creating any new federal bureaucracy or new systems for accountability that would fail to recognize existing quality improvement and accreditation programs.

Our reform proposal includes:

- A defined role for organized medicine and practicing physicians on any national public or quasi-public body dealing with quality issues;
- A provision for input by the medical profession in the development, implementation, and evaluation of quality management programs at the state and health plan levels;
- A provision for input from consumer and patient representatives about quality issues (e.g., access to performance data, confidentiality of medical records, satisfaction with physicians and other providers);
- Establishment of a private/public partnership to implement a national quality program that strengthens existing private sector efforts in quality, utilization and outcomes management -- instead of government control over quality programs. This partnership establishes a national advisory body on quality of medical care and will provide for the exchange of information among quality programs, oversee the establishment of performance measurement systems, and shall have deemed status to accredit and approve quality programs. The partnership would:
 - Develop principles for quality management;
 - Develop principles for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data;
 - Develop mechanisms, such as provider report cards, to assure the public availability of information and to inform patients and purchasers about local health plan performance and to promote both quality and competition in the marketplace;
 - Develop interventional tools and education programs to change practice patterns;
 - Develop strategies for and coordinating effectiveness research and technology assessment;
 - Develop principles of utilization management; and
 - Establish priorities for guideline development through analysis of variations in practice.

Freedom of Choice

Currently, too many individuals have only limited choice of health plans offered by their employers and their access to physicians under these plans also is often restricted. In a reformed system, the individual - not the employer -- should have the right to select from all qualified health plans in their area, including fee-for-service, HMO, PPO, and benefit payment schedule plans. This will ensure that individuals are able

to choose both their physician and their preferred method of paying for health care.

Our proposal specifically recommends that:

For Patients

- Individuals shall be entitled to select from any qualified health plan -- fee-for-service, PPO, HMO, or benefit payment schedule -- offered in their geographic area.
- All health plans, including HMOs, must offer individuals the option of purchasing a "point of service" rider. This rider, which must be offered by plans at time of enrollment and at least annually thereafter, would entitle individuals to seek care from any physician -- whether in or out of the plan -- and have coverage for such care as defined in the comprehensive benefit package.
- Any health plan restriction of access to services or providers must be disclosed to and acknowledged by the enrollee.
- All insurers and health plans must pay for case management services/coordination of care delivered by qualified health care professionals to promote more coordination of services across specialties for the benefit of patients.

For Physicians

- Physicians shall have the right to apply to any health plan or network and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualification, competence, and quality of care. However, health plans or networks may develop and use physician-developed criteria to determine the number, geographic distribution, and specialties of physicians needed.
- Managed care organizations and third-party payers shall be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed.
- Health plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians shall report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, costs, and choice of health care services provided to patients enrolled in such plans or networks.
 - In any case in which selection criteria, especially economic criteria, may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken.
- Managed care plans and medical delivery systems must include practicing physician involvement in their health care delivery policies similar to those of self-governing

medical staffs in hospitals. Physicians participating in these plans (and no physicians should be arbitrarily excluded) must be able, without threat of punitive action, to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including practicing physician representation on the governing board and key committees of the plan.

Cost Containment

Rising health care expenditures are driven by many factors: inflation, new and expensive technology, and health conditions associated with increasing societal problems such as violence, drug abuse, poverty, and HIV infections. For too many individuals, the rising costs threaten their access to needed services and their ability to pay for medical care.

Our proposal's approach to cost containment focuses on increasing competition in the marketplace. The proposal would foster competition by:

- Encouraging cost-conscious decision-making by patients through the provision of clearly-understandable price information for physician, hospital, and other services and the extent of insurance payment for covered services. Insurance companies and physicians that use a relative value scale methodology could make available to the public their conversion factor and other necessary information so that patients can determine the extent of insurance payment for a particular service;
- Requiring employers and insurers to offer individuals a choice of health plans and financing mechanisms.

The AMA proposal would also:

- Establish a negotiated goals approach -- rather than premium caps or strict global budgets -- that involves physicians in establishing reasonable health care spending goals that take into account demographics, disease, technology, and demand factors.
- Such a negotiated approach is in direct contrast to strict global budgets or spending caps -- both of which would result in rationing of health care services and would conflict with society's obligation to ensure that no American goes without health care coverage.

- Utilize practice parameters and utilization guidelines to enhance quality, cost-effective and outcome-effective care.
- Establish that for those individuals below 200 percent of the federal poverty level, insurance payment must be accepted as payment in full.
- Effect major professional liability reform to reduce the inappropriate costs of defensive medicine and liability insurance premiums.
- Simplify the system through reduction of paperwork and government regulation and standardization of managed care requirements, claims procedures, review practices, and disclosure policies.
- Create a level playing field for the self-insured and the insured alike through the amendment of ERISA to assure provision of secure, standard benefits and fairness of treatment for all.
- Cap the deductibility of employer-provided health insurance at an appropriate ceiling such as 125 percent to 133 percent of the geographically-adjusted costs of the required comprehensive standard benefit package. This cap would apply to the employer and the employee and would foster prudent use of services and raise needed revenue to fund coverage for currently uninsured and underinsured Americans.

Scope of Practice

The AMA supports appropriate collaboration among physicians and other health professionals within the scope of their education and training to achieve the best results for patient care. Determinations of "appropriate" collaboration should be mutually-developed through interdisciplinary discussions.

Standards for determination of scope of practice for various health professionals should be established at the state level, including provisions that would preclude inappropriate restriction of practice by those professionals demonstrating educational and clinical competence.

Our proposal specifically recommends:

- National studies to identify those programs where physicians, nurses, and other health professionals have been working on a collaborative basis both successfully and unsuccessfully and to disseminate such information broadly.
- These studies should also provide support for the interdisciplinary discussions on a mutually-acceptable definition of "collaborative practice" and for discussion of such issues as reimbursement for services and the identification of advance practice nursing roles in the hospital and community settings.

Physician Workforce

Currently, there are an inadequate number of physicians in primary care specialties. This problem needs to be addressed. Our proposal specifically recommends:

- A private sector consortium/initiative, independent of control by any single group, that would develop positive incentives (e.g., loan forgiveness) to increase the proportion of physicians who enter and remain in primary care specialties and practice in underserved areas.
- Preservation of student and resident freedom of specialty choice -- in contrast to the imposition of workforce quotas and the use of negative sanctions.
- Participation by all payers in the funding of graduate medical education.

Simplifying the System

The current health care system is fragmented, costly, complicated and characterized by duplicative and confusing paperwork and government regulations. To allow more time for patient care activities -- and to improve access and help contain health care costs -- administrative simplification must be a core element of any health system reform initiative. Our proposal includes the following specific changes:

Administrative Changes

- Reduce the complicated paperwork nightmare faced by patients and their families by requiring that all insurers and the government use a simple, uniform claim form.
- Provide incentives to encourage physicians and other providers to file benefit claims on behalf of their patients.
- Provide incentives to encourage health insurers to use a standard electronic billing format and to encourage physicians to utilize this method of filing claims on behalf of their patients.
- Standardize and disclose utilization review criteria to patients and physicians.
- Reduce the regulatory and costly burden of unnecessary government programs.

Financing Reform -- Who Will Pay?

The provision of health coverage to all Americans could be assured through a variety of approaches, such as through a blending of responsibilities of employers, individuals, and the government. There is no single best mechanism. Revenue for expanding coverage to all Americans would be generated by the AMA recommended employee/employer tax cap and an excise tax of at least \$2 per pack on cigarettes. As necessary, additional revenue for financing the government's contribution to universal health care coverage could be raised from broad-based taxes -- rather than inappropriate spending reductions in the Medicare

and Medicaid programs.

In Sum, The Time for Action Is Now

This proposal offers a comprehensive solution to reforming our health care system that blends competitive forces in the marketplace with societal responsibilities to ensure affordable health care coverage for all Americans. This proposal would also reaffirm the physician's role as patient advocate and reinstate the patient's right to reach health care decisions with their physician unencumbered by corporate decisions that often place profits above patients.

We call upon all parties to seek common ground in establishing an improved health care system for all. We stand so ready. We strongly urge the Congress to pass a health system bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Mr. WAXMAN. Mr. Kahn.

STATEMENT OF CHARLES N. KAHN

Mr. KAHN. Good morning, Mr. Chairman and members of the committee. My name is Chip Kahn. I am the executive vice president of the Health Insurance Association of America. HIAA represents 236 commercial insurers covering over 55 million Americans. HIAA welcomes the opportunity to provide our views on health reform.

HIAA wholeheartedly agrees with the primary goal of H.R. 1200, the American Health Security Act, to assure all Americans the peace of mind and security of health insurance coverage. HIAA agrees that to be coverage under a comprehensive set of benefits, measurable quality and outcome standards, physician choice and administrative simplification. Reform must include a shift in emphasis away from sickness and repair and toward health and wellness.

However, we disagree strongly with the approach taken by H.R. 1200. We believe the government is not the most appropriate mechanism for delivering health insurance coverage to all Americans. HIAA feels government should be an enabler, not the controller. Instead, health coverage for all nonelderly or disabled Americans should be achieved with private health insurance.

To make it work, all health plans should be subject to a single set of rules that govern marketing of insurance as well as guaranteed continuous coverage. We must ensure health security for all Americans. No one should lose coverage because of sickness, changing jobs or losing a job. We can best meet the goal by building on our employer-based system to create a consumer-responsive, prevention-focused, affordable and cost-effective health care delivery system.

The President in his plan has made it clear that the best route to universal coverage is through an employer-based private health insurance system. The act of participation of employers in financing, selecting and administering of a comprehensive health benefits package is critical to maintaining the open, flexible and innovative health care system which serves America so well today.

According to our latest employer survey released in November 1993, 81 percent of employees covered by group benefit plans are satisfied with their coverage. Satisfaction levels have been found to increase in all plan types since 1990. It is upon this base that universal coverage should be built.

In contrast, it appears to some that the adoption of a single-payer, government-run health insurance system would be a simple way to meet the challenge of universal coverage. Unfortunately, using such means to obtain universality is neither practical nor realistic in the context of American society and economy.

If we try to provide unlimited care to everyone financed through a shift of dollars from private sector to the public till, eventually something has got to give. Either the care will suffer, or we will bust the budget.

One of the major rationales for government-run national health insurance is that it would be less expensive than our current system to administer. Clearly, certain costs remain greater in our plu-

realistic system than in a single-payer approach. We believe firmly that reform will make our system less expensive and more than justify the administrative costs which accompany private versus public health insurance.

What we need from reform is not to make promises at the expense of the taxpayers but to provide all Americans with the coverage that most of us now enjoy. Reform can only be made affordable over time if we build upon the lessons of the last few years where employers, consumers and health plans have worked together to reduce the costs of care.

To be frank, it is unlikely that an unbridled for-service government health plan can help control costs. Government price setting has never worked. As cost containment strategy, it cannot match the innovation that has and will come when those affected work together to reduce the costs of care and thus make coverage affordable for all Americans.

In closing, let me emphasize that I am not defending the status quo. I am simply arguing, as the administration has, that we need to build on what works and bring that to all Americans. Towards this end, we hope Congress will focus on how to make coverage affordable, available to all Americans through private health insurance.

HIAA stands ready to assist this subcommittee in its deliberations in the forthcoming year to achieve a solution to health care reform which will assure all Americans health security.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Kahn.

[Testimony resumes on p. 673.]

[The prepared statement of Mr. Kahn follows:]

STATEMENT OF HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Charles N. Kahn III, Executive Vice President of the Health Insurance Association of America (HIAA). HIAA represents approximately 236 commercial insurers covering approximately 55 million Americans. HIAA again welcomes the opportunity to provide you with our views on health care reform.

HIAA wholeheartedly agrees with the primary goal of H.R. 1200, the "American Health Security Act", to "give to all Americans the peace of mind -- the security -- to which all citizens should be entitled." We agree that we must address the problems in our nation's health care system.

HIAA embraces many of the building blocks upon which the "American Health Security Act" is based -- universal coverage under a comprehensive set of benefits, measurable quality and outcomes standards, physician choice, and administrative simplification. Reform must include a shift in emphasis away from sickness and repair and toward health and wellness. However, we disagree with the bill's cosponsors that the government is the most appropriate mechanism for delivering health coverage to all Americans. HIAA advocates that government should be an "enabler" not a "doer."

Reform must build upon our employment-based system. Employers' active participation in financing, selecting, and administering an essential health benefits package is critical to maintaining the open, flexible, and innovative health care system to which Americans have become accustomed, and which today serves most Americans well. Employers have a unique interest in maintaining employee health -- it affects productivity. Employers must provide and contribute toward coverage for all their employees and dependents. Government should not shirk its role; it must help subsidize those employers and individuals who cannot afford to purchase an essential benefits package. All individuals -- those employed and those not connected to the work force -- must be required to obtain coverage and should receive tax incentives to purchase the essential package.

We believe that the essential package should cover primary, preventive, and catastrophic care. There should be a federally defined benefit package. The package should be flexible to encourage cost-conscious behavior. Americans should be encouraged to take personal responsibility for maintaining good health, and should be discouraged from indulging in unhealthy behaviors, such as smoking.

Once we have achieved coverage for all Americans, all health plans should be subject to a single set of rules that will govern market behavior and guarantee universal, continuous coverage. Coverage should be made available to every employee in a group without regard to health status. Use of claims experience rating and preexisting condition limitations should be eliminated. **We must guarantee health security for all Americans -- no one should lose coverage if he or she gets sick, changes jobs, or loses a job.**

The system must be streamlined and be made more "user-friendly." Our health care system is awash in a sea of paperwork. HIAA supports standard guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system. Collecting and disseminating appropriate outcomes data and practice guidelines should be a component of any health care reform package.

HIAA believes that all Americans are entitled to health care coverage. To achieve this goal we should build on our employer-based system to create a consumer-responsive, prevention-focused, affordable, and cost-effective health system. We do not believe that a government, single-payer type system would provide the service or access to technology that most Americans expect and deserve.

I sympathize with the supporters of the "American Health Security Act;" they desire a simple solution to this nation's health care woes. All of us -- including the insurance industry -- are concerned about the more than 37 million Americans who do not have health care coverage. Adopting Canadian-style, single-payor public health insurance seems like the magic solution: everybody is covered and it appears to be cheaper.

My message to you today is: It is unfortunately not that simple. There is no free lunch, as the economists like to say. If you try to provide free health care to everybody on a fixed government budget, eventually something's got to give. The consequences are very clear from the Canadian experience.

In the debate over health care reform in the United States, the advocates of a Canadian-style, government-run health insurance system emphasize two points: Health care is cheaper in Canada, and everybody is covered. Let's examine each of these statements in turn.

Indeed, health care is cheaper in Canada, both per capita and as a percent of total economic output. But does that mean Canada has solved the problem of health care cost inflation? No. And is universal public health insurance the reason Canada spends less than we do? There is strong evidence to suggest that the answer to that question also is no.

First, Canada has not solved the problem of health care inflation. Health care costs per capita are rising at basically the same rate in Canada as in the United States. Specifically, from 1971 (the first year universal public health insurance was in place throughout Canada) through 1991 (the latest year for which information is available), health care spending per capita rose an average of 10.60 percent per year in Canada, compared to an average of 10.64 percent per year in the United States.¹ [see attached Figures 1-4]

¹ Source: HIAA analysis of national health expenditure data from the Organization of Economic Cooperation and Development

This result seems surprising in light of the well-publicized fact that Canada today spends a lower percentage of its total economic output on health care than does the United States, although it spent a higher percentage than the United States prior to 1967. Analysis suggests that the reason for this apparent anomaly lies in the relative growth rates of the two economies. Canada's economy has grown much faster than ours over the last two decades.² Thus, even though their health care costs were growing as fast as ours, their faster-growing economy "covered" those cost increases.

Moreover, there was no sharp reduction in health care spending in Canada when public coverage of medical services became universal. In fact, per capita spending in 1971, the first year of complete universality, was 12.4 percent higher than in the previous year (compared to a 9.5 percent growth rate in the U.S. that year). Thereafter, the growth rate slowed significantly for a couple of years, but soon resumed a pattern almost identical to that of the United States.

My point is this: Canada may spend less than the United States does on health care, but that difference did not result from adoption of its public insurance system. On a per capita basis, Canada spent less than we did before its public system was fully in place, and since then, a similar rate of health care inflation has allowed it to maintain that difference. Thus we should expect no "fiscal dividend" -- no dramatic savings -- from implementing a public health insurance system anywhere in the United States.

Let me turn now to the access question. "Everybody has access" in Canada, the advocates say. Well, yes, but access to what? Can every Canadian get to see a doctor when they have the flu or their child has an earache? Does every Canadian have prompt access to medically necessary care?

As you no doubt know, newspapers in Canada are routinely full of stories about long waiting lists for certain kinds of medical care, primarily "high-tech" diagnostic tests, such as magnetic resonance imaging, and expensive forms of surgery, such as coronary artery bypass grafts and hip replacements. It may be tempting to dismiss these reports as "anecdotal" but there are so many reports that I don't believe they can be dismissed.

Fortunately, we don't need to rely solely on newspaper accounts to understand this phenomenon. The Vancouver-based Fraser Institute has examined the extent of waiting lists in Canada by surveying specialists in ten provinces. They estimate that, across Canada, more than 177,000 people are waiting for surgery³. Average waiting times vary by type of surgery and by province. People must endure lengthy waits

² Between 1971 and 1990, total economic output per capita in Canada -- measured in constant dollars -- grew 60.5 percent. The comparable figure for the United States is only 37.2 percent.

³ Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," Fraser Forum, May 1993.

before meeting with a specialist and even longer waits before obtaining needed surgery. [See Chart 1]

- The average wait to see an eye specialist in Prince Edward Island is six months.
- On average, it takes almost seven weeks to see a gynecologist in New Brunswick.
- Patients in British Columbia wait up to a year for routine procedures such as cholecystectomies, prostatectomies, hip replacements and surgery for hemorrhoids and varicose veins.⁴
- In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan, and up to two years for lithotripsy treatment.⁵
- All over Canada, patients wait for coronary bypass surgery.
- On average, it takes about five weeks to see a specialist in all 10 Canadian provinces. However, the average wait varies widely from province to province.
- After seeing a specialist, patients wait an additional 14.6 weeks for surgical procedures in Prince Edward Island and only 5.9 additional weeks in Ontario.
- Following a diagnosis, a high proportion of patients in the Maritime provinces wait more than six months for treatment, but 96 percent of the waits in Ontario are less than three months.

As the waiting lines grow for virtually every type of treatment in every Canadian province, America serves as Canada's safety valve. In increasing numbers, Canadians cross the U.S. border to get care they cannot get at home. For example:

- Because of the inadequate facilities in Canada, about half of the in vitro fertilization patients at the University of Washington Medical Center are Canadians, paying \$5,000 out-of-pocket for each procedure.⁶
- In 1990, the Ontario Health Insurance Plan paid about \$214 million to U.S. doctors and hospitals — up 45 percent over the previous year.

⁴ Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, 1990.)

⁵ General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, June 1991, Table 4.1, p.55.

⁶ John K. Iglehart, "Canada's Health Care System Faces Its Problems," *New England Journal of Medicine*, Vol. 322, No. 8, February 22, 1990, p.566.

Health care budgets have gotten particularly tight in the Canadian provinces in the last few years. Ottawa began to restrict its contribution to the provincial health plans in the mid-1980s and, at the end of the decade, froze its per capita contribution at the 1989-90 level for the foreseeable future. The result has been considerable turmoil at the provincial level, as the provinces struggle to keep health spending from breaking the budget. Canadian province debt today is almost \$190 billion (Canadian). (Health spending consumes about a third of provincial budgets.)

According to a December 25, 1993 Washington Post article, "hospitals in the province of Ontario, home to one third of all Canadians, closed many of their beds and operating rooms and suspended availability of some treatments for two to three weeks over the holidays to achieve severe government-imposed spending reductions. The holiday shutdowns underscore how governmental budget problems are increasingly controlling the way Canadians receive health care."

Tight budgets lead hospitals to look for all sorts of ways to cut corners. Often, the means they choose make care in a hospital less comfortable for their patients. For example, Montreal's Royal Victoria Hospital doesn't use the latest type of injectable dye for X-rays. It saves \$650,000 (Canadian) per year, but the older type of dye is less comfortable for patients. When new beds were needed, manual-crank models were bought, so now patients need to call a nurse to change the position of their beds. Maternity patients must bring their own diapers for their newborns.

The relative scarcity of the newest generation of medical technology in Canada is well-documented. Chart 2 gives the latest available statistics comparing access to modern medical technology in the United States and Canada, based on information from *Medical Economics* magazine.⁷ As the chart shows:

- On a per capita basis, the United States has ten times as many magnetic resonance imaging (MRI) units – which use magnetism instead of x-rays – as Canada.
- The United States has three times as many computerized axial tomography (CAT) scanners per person.
- The United States also has about three times as many lithotripsy units (to destroy kidney stones and gallstones with sound waves) per person.
- And, per capita, the United States has about three times as many open-heart surgery units and eleven times as many cardiac catheterization units (for the treatment of heart disease).
- The rate of pacemaker implantation in the United States during the mid-1970s was almost 20 times that of Canada.

⁷ Source: "Queues and Cooperation: The Canadian Approach to Rationing," *Medical Economics*, 1993.

Canada develops almost no new medical technology and spends very little on research and development. By contrast, research and development spending in the United States results in innovations that benefit the U.S., Canada, and the rest of the world. While there is little doubt that America has splurged on high-tech medical equipment, there is also little doubt that Canada has not invested enough to maintain proper quality of care. The chairman of radiology at the University of Toronto, Walter Kucharzyk, has said, "I can point to about a dozen cases a year at my center where someone's health was directly jeopardized because they couldn't get an MRI."

Why does Canada limit the supply of high-tech medical equipment? And why are budget cuts forcing the closing of hospital beds? One likely reason is that too much unnecessary care is provided. It is a well-documented fact that, when health care is "free" at the point of service, people use much more of it. The Rand Health Insurance Experiment in the 1970s demonstrated this fact clearly in several sites throughout the United States, and the Canadian experience confirms it. Between 1971 and 1985, per capita utilization of physician services grew much more rapidly in Canada than in the United States: 68 percent over that 14-year period, compared to 49 percent in the U.S. It has been noted that, during the last decade, Canada's population grew by 10.5 percent, while use of medical services grew 42 percent. H.R. 1200 has no out-of-pocket payments for most services, which could lead to a utilization explosion of health care services.

The Congressional Budget Office has estimated that enactment of H.R. 1200 would raise national health expenditures at first but would reduce spending by 6 percent in 2003. While we agree that on the surface a publicly run system may be less expensive, there is no reason to assume that the government will show the needed fiscal restraint in health care when they have failed to restrain other government programs. CBO Director Robert Reischauer testified before the House Ways and Means Health Subcommittee on May 25, 1993 that the figures should be used "with caution" because of the "great deal of uncertainty surrounding the estimates." Reischauer also said that new methodology suggests the savings from administrative simplification could be lower than CBO estimated.

Government-run systems are subject to "rough justice" where policies are made in the aggregate without regard to individual needs or innovation. Thus, government health insurance programs in most other countries, such as Canada, typically address cost control by simply limiting physician fees and putting a cap on hospital expenditures without changing the way medical services are rendered. In Canada, all major hospital decisions to invest in new technology or services must be approved by the provincial governments. Because the dramatic growth in health care costs is only partially related to prices (no more than one-third), government price controls will arbitrarily limit access to care. Price controls in general, whether on providers or services, are not good economic policy and are politically difficult to sustain.

The consequences of this kind of approach are clear from the Canadian example. New, high-tech services simply are not adequately available in Canada, and therefore, patients who need them have to wait in line. A recent Harvard School of Public Health study reveals that Canadian doctors "are highly concerned about their ability to get access for their patients for special care and medical technology."

Overall, Canadians wait three times longer than Americans to see specialists and to have elective surgery, according to the 1992 Harvard study.

This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, bureaucratic budget control discourages innovation, perpetuates existing inefficiencies, and leads to obsolescence.

The essence of the American health care system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness and maintaining health. Such responsiveness is clearly not possible when all major resource allocation decisions are made by government.

In a top-down, budget-driven system, especially one that promises free care to everyone, it's very hard to get rid of the waste and unnecessary care that everyone agrees is there. A government budget is a blunt instrument, and the easiest way to meet a budget is just to say, "Don't do anything new," or at least, "Don't do very much of it."

One of the major rationales national health insurance advocates give for their claim that U.S. government-run health insurance would be cheaper than our current system is that administrative costs are lower in government-run systems. Canada and Medicare are the examples usually cited. No doubt there are some administrative functions that become unnecessary under a government-run program. But, more often, the functions and costs are still there but are simply ignored under government accounting rules. Private insurers, for example, must set aside contingency reserves against the risk of unexpectedly high medical claims. Government simply squeezes payments to providers in an attempt to meet budget targets.

Also frequently ignored is the fact that one of the major "administrative costs" incurred by insurers is the premium tax they pay to state governments, along with other taxes and fees. This amounts to about 3 percent of total premium. These tax revenues would be lost if a government-run system were to be put in place.

But let's put this administrative cost issue in proper perspective. Clearly, it costs us more to administer our pluralistic health care system than it costs the Canadians to run their unitary system. The issue is not so much what it costs but whether we get something of value in return. For example, in this country you can mail a first class

letter for 29 cents, if you want to. But if it absolutely, positively has to get there the next day, many people willingly pay much, much more. I think there are two main areas where private insurance is out-performing government insurance in this country. First is service and second is the commitment to managing care for cost-effectiveness and quality. It's pretty clear to me that one of the reasons Medicare is less expensive to administer is that it provides no customer service. Both patients and providers say that it's impossible to reach Medicare on the phone to deal with a payment problem. I'm sure you get those complaints in your offices every day from constituents. In the private market, on the other hand, providing good service is one of the ways insurers compete for business.

More important, over the past 10 years private insurers have invested literally billions of dollars to establish managed care networks because they believe that managed care is the rational way to make our health care financing system more efficient while preserving high quality care.

In closing, let me emphasize that it has not been my intent today to defend the current U.S. health care financing system as perfect, nor to portray the Canadian system as inhumane or inept. Clearly, we must develop and adopt improvements that will extend affordable health care coverage to all Americans. The question is not whether we should address this problem. We should. Rather, the question is whether we should pursue a solution that builds upon what is good about America's health care financing and delivery system, or adopt an approach that would abruptly sweep away our present structure and substitute a radically different approach. We believe that a monolithic, government-administered health plan would not work in this country. There are no simple, unidimensional solutions to our health care dilemma. There are trade-offs among access, quality, convenience, and cost. We believe most Americans would find the Canadian approach unacceptable if it were to be applied here.

Total National Health Expenditures as a Percent of Gross Domestic Product

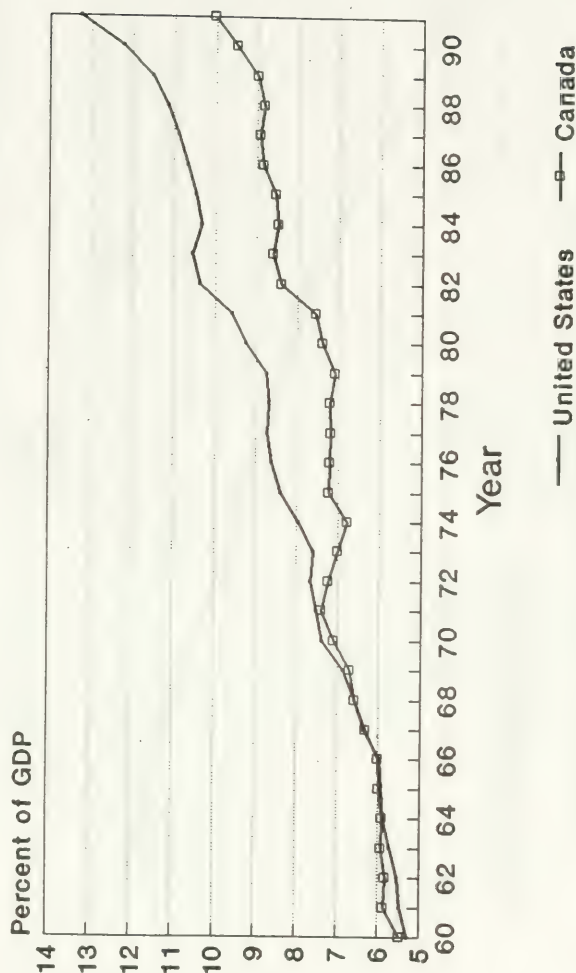


Figure 1

Cumulative Increase in Real Health Spending Per Capita Since 1960

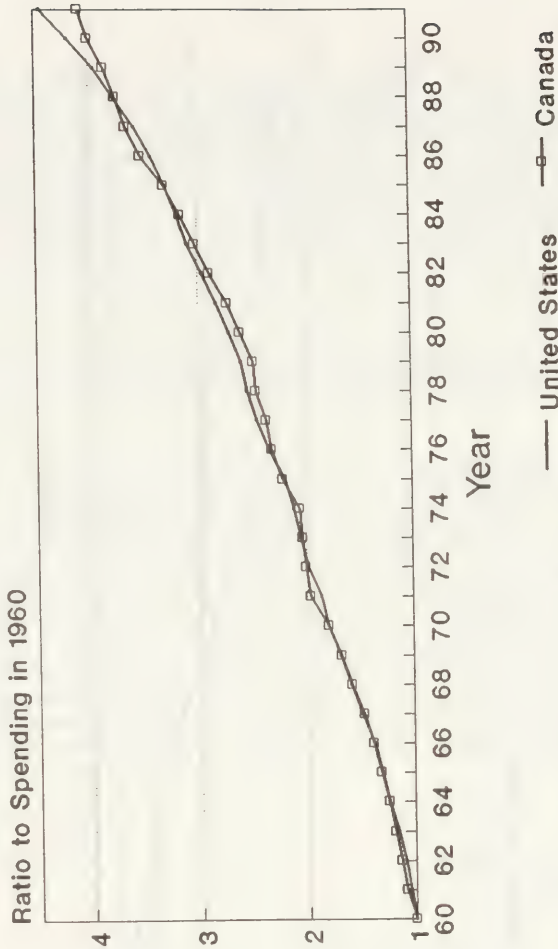
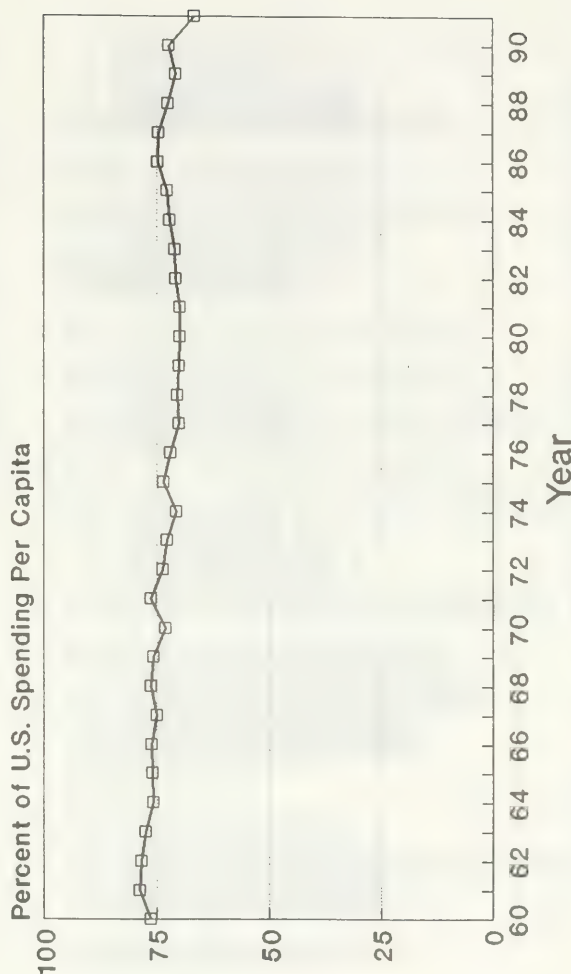


Figure 2

Health Care Spending Per Capita: Canada as Percent of U.S.



Currency conversion using OECD
purchasing power parity exchange
rates for each year.

FIGURE 3

Average 5-Year Growth Rates of Real Per Capita Health Spending

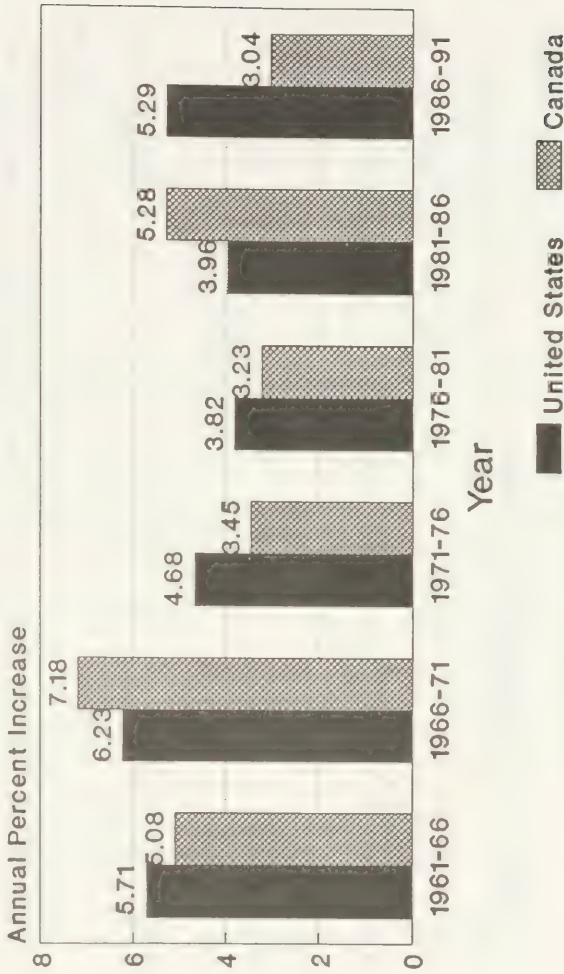
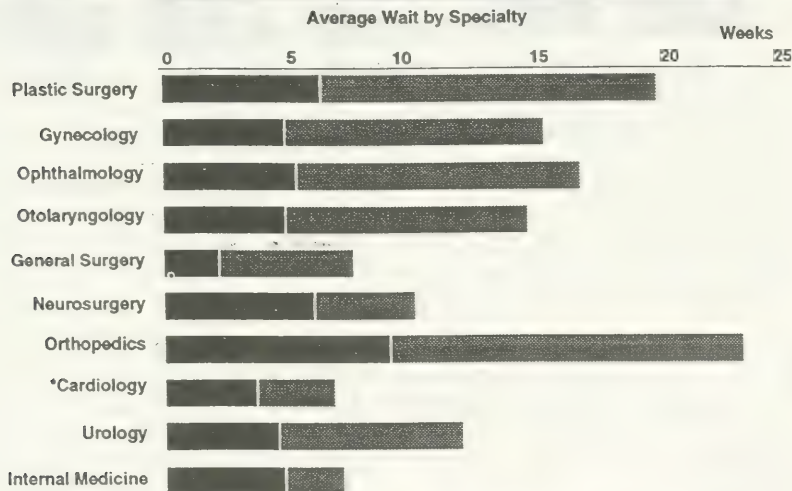
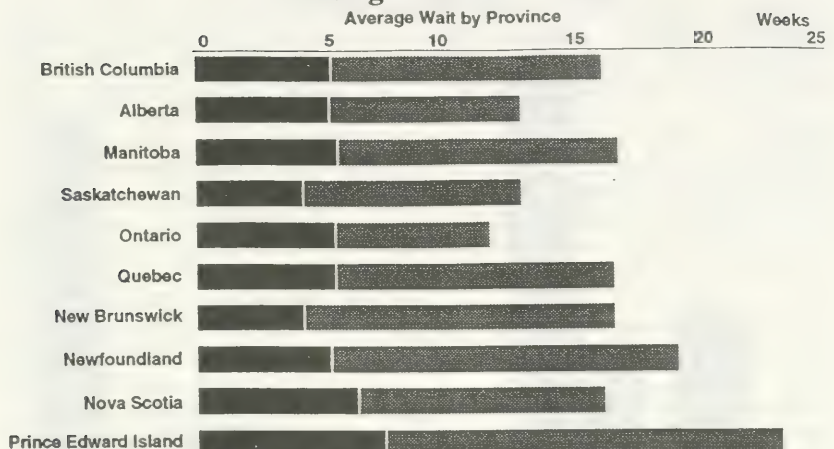


Figure 4

CHART 1

Waiting Times in Canada



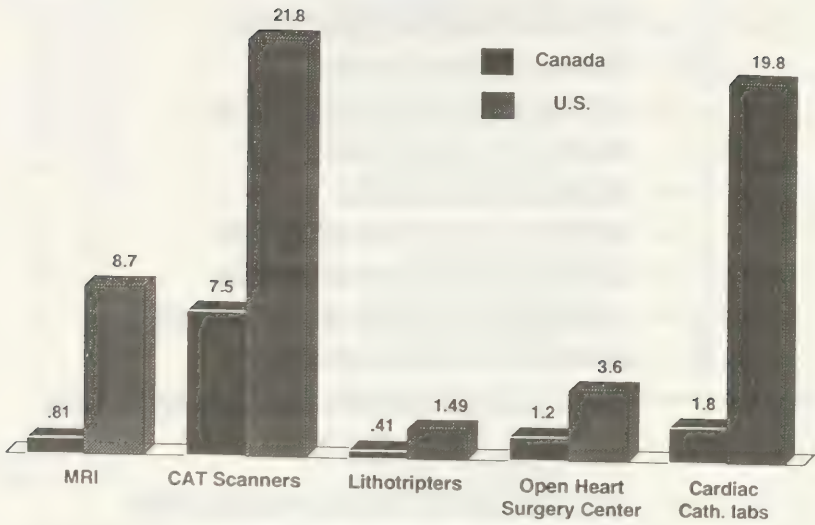
■ Time between general practitioner referral and appointment with specialist.

■ Time between meeting with specialist and treatment.

Source: Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum*, May 1993.

*Cardiology waiting time is for urgent surgery only. Elective surgery waiting times averaging as much as 48 weeks are also experienced. (Elective surgery patients are those for whom there is no immediate life threat.)

CHART 2
Technology Comparison
(per million people)



Source: "Queues and Cooperation: The Canadian Approach to Rationing," *Medical Economics*, 1993.

Mr. WAXMAN. Mr. Huard.

STATEMENT OF PAUL HUARD

Mr. HUARD. Thank you, Mr. Chairman. I appreciate this opportunity to testify on behalf of NAM's 12,500 members, approximately 8,500 of which have 500 or fewer employees, and, according to our surveys, 97 percent of which provide health care coverage for their employees.

Let me state, in general, that NAM is fully supportive of achieving the goal of health care reform that will result in universal coverage for all Americans in an employment-based system, a pluralistic system operating under a Federal framework. We believe such a system must give employers incentives to provide benefits, must give providers incentives to deliver quality care and must give consumers benefits to use benefits wisely.

In our view, given the political, economic and cultural history of the United States, market-based solutions are the best approach to achieving these goals.

In this regard, I would note in passing that both Congressman Cooper and Senator Chafee have introduced legislation that has a significant market orientation. The administration's health care reform bill has some market-based elements but for the most part is heavily regulatory and bureaucratic.

At this time, NAM has not endorsed any of the pending bills. I think it is safe to say that we would not support H.R. 1200 which basically would nationalize the U.S. health care system.

Our objections to H.R. 1200, which are detailed in our written testimony, are as follows, and I will summarize them very briefly:

First, we do not believe it will save money. The cost history of the Federal entitlement programs going all the way back to Social Security, Medicare, Medicaid is hardly encouraging in this regard. It is, basically, one of consistently underestimating of what the program will cost.

Second, in H.R. 1200 there is, essentially, no meaningful role for employers. The employer's role is simply to pay. How much to pay and what to pay for is essentially dictated by the government.

Third, as has already been noted, it fails to address the medical malpractice liability reform issue which we believe any viable reform plan must address.

Fourth, it relies on global budgets which is, basically, a form of price controls. Our view of price controls is they have never worked over any significant period of time. They certainly do not appear to have worked well in Canada.

Fifth, there are no incentives in H.R. 1200 to make consumers of health care services cost conscious as to the services they are utilizing. There is no provision for deductibles, co-payments or anything. These are all devices which have been shown to work well when properly applied.

Sixth, government control is not, in our view, either politically, economically or culturally acceptable to the vast majority of Americans. Here, again, the history of the government-run enterprise, whether it is the postal service or how many right answers you can get from the Internal Revenue Service when you call up with a relatively simple question, is not an encouraging track record.

Let me say in conclusion that we do support the goal of comprehensive reform legislation that will achieve universal coverage. I think we are in agreement with the entire Congress and virtually all of the witnesses who testified. It is just a question of technique. We really think that a technique which ignores the employment-based system which we believe could be made to work more efficiently is the wrong approach and that a bureaucratic nationalized system is not desirable.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 688.]

[The prepared statement of Mr. Huard follows:]

Testimony of

Paul Huard

Senior Vice President, Policy and Communications

National Association of Manufacturers

on

The American Health Security Act - H.R. 1200

before the

Energy and Commerce Committee

Subcommittee on Health and the Environment

February 1, 1994

Mr. Chairman and members of the Subcommittee, I am Paul Huard, Senior Vice President for Policy and Communications, National Association of Manufacturers. Accompanying me is Sharon Canner, NAM's Assistant Vice President for Industrial Relations. I am pleased to appear today on behalf of NAM's 12,500 member companies, 8,500 of whom have fewer than 500 employees. Over 97 percent of these firms, according to a 1992 survey, provide health coverage.

We commend you, Mr. Chairman, for convening this hearing today to explore solutions to the problems of our health care system.

American manufacturers have consistently demonstrated a broad commitment to providing employees and their families with good health benefits. We therefore have a vested interest in the current debate and support comprehensive reform within a federal framework. In our view, market-based solutions are the best approach, given the United States' political, economic and cultural history. Such a system gives employers incentives to finance and administer benefits, providers incentives to deliver quality care and consumers incentives to use benefits wisely.

Rep. Cooper's bill (H.R. 5222) and Senator Chafee's bill both offer market-based approaches. President Clinton's bill contains some market-based elements, while other provisions are regulatory in nature. The NAM does not support any particular reform bill at this time.

This testimony will make general comments on H.R. 1200, offer observations on the Canadian system and why it is not likely to work in the United States, and make recommendations on market-based reform.

The American Health Security Act (H.R. 1200)

The American Health Security Act introduced by Rep. Jim McDermott (D-WA) in the House and a companion bill (S. 491) introduced in the Senate by Senator Paul Wellstone (D-MN) would create a publicly administered national health program, virtually eliminating all existing private health insurance. Financing would come from an 8.4 percent payroll tax on employers (4.0 percent on small low-wage firms), a 2.1 percent levy on an individual's taxable income, increased excise taxes on cigarettes and a new excise tax on handguns and ammunition.

While S. 1200 would appear to meet the goals of achieving universal coverage, portability of benefits and controlling costs through a global budget, it would do so at tremendous economic cost and likely compromise the standards of care to which Americans have become accustomed. Although CBO reports that H.R. 1200 would save \$100 billion a year in administrative costs, we remain skeptical that the American Health Security Act is truly a better deal for employers, employees and others, in general. Government estimates--projected costs of Medicare, for example--are often dramatically wrong.

Most importantly, single payor health insurance as proposed under H.R. 1200 fails to recognize certain cultural, political and social characteristics unique to Americans. For this reason, single payor health insurance, a model found in Canada and other nations, is not likely to work in this country. Some of these factors are addressed below.

Cost-sharing. H.R. 1200 prohibits deductibles or copayments for acute care and preventive services and also prohibits providers from balance billing consumers for acute care or preventive services. Consumer cost-sharing, as shown in studies such as the Rand Corporation health insurance study, does reduce utilization as well as control plan costs. In fact, several Canadian provinces are now considering cost-sharing (no cost-sharing is currently permitted in Canada) as a means to reduce their governmental outlays.

Medical Liability Tort Reform. The American Health Security Act does not include provisions to address medical liability tort reform and its relationship to defensive medicine costs, which

are estimated to add 10 to 20 percent to health costs yearly. According to a 1993 study (Lewin-VHI, Inc.) medical liability tort reform would save \$36 billion over a five year period.

Global Budget. Inefficient delivery of care, consumer demand and use of unnecessary care are major drivers of health costs. Global budgets do not address these factors. Setting the budget too low could diminish quality and lead to rationing, a situation now facing some segments of the Canadian system. Setting the budget too high, may encourage providers to raise their prices above what they should be. A global budget would lock in current patterns of care and discourage providers from delivering new services not funded in their current budget.

Government-set budget limits would inevitably fail to match health care resources within patient needs. In Canada, where annual limits have been placed on hospital spending, some patients remain hospitalized 50 percent longer than in the U.S., while other patients wait a year for hip replacement surgery.

Employer Role. A single payor system eliminates the employer role in designing, administering and financing health benefits. Nearly 85 percent of Americans are covered by employer-based health benefits, which has worked well for most Americans. Most employers want to retain this system, while recognizing that major improvements are necessary. Few would replace this system by borrowing a model from another country with different social and cultural values. When asked if they preferred a tax-financed single payor system in a 1992 survey, only 10 percent of NAM members selected this choice from among a range of options that included

fixing the current system, individual mandates, employer mandates, pay-or-play and other approaches.

In recent years, many employers have taken an aggressive approach to manage their benefit programs through intensive use of managed care, working together in buying cooperatives, entering into performance-based contracts with providers and educating their employees to be better consumers of health care. Plan sponsors are reluctant to become payors only, believing they are better qualified to actively manage their benefit dollars, rather than the government.

Some employers now pay less for health care than the 8.4 percent of payroll called for under H.R. 1200. At the same time, future costs may require that the 8.4 percent be increased. Employers would have no control over how that money is spent.

The Canadian Health Care System vs. U.S. Cultural, Social and Political Values

The single payor system with which Americans are most familiar is that of Canada. Over the past few years volumes of information on the Canadian health care system have been published in scholarly journals, and in newspapers and magazines. Programs frequently appear on radio and television.

Generally, this information focuses on the advantages and disadvantages of the single payor Canadian model without discussing the legislative, judicial and cultural underpinnings which make that system work in Canada. Only when those factors are clearly understood can we

determine whether that system, or parts of it, is the right approach for the United States.

People often speak of the Canadian health care system as if it were a monolith. It is not. There are 10 provincial and 2 territorial systems. As the Canadian government implements its announced intention to reduce to zero its health block grants, more significant interprovincial differences may occur, particularly in the less prosperous provinces.

Cultural and Political Differences. Canada is geographically a huge country. Most people, however, live near the U.S. border. It is our largest trading partner, yet largely overlooked by many Americans. There are differences and they are significant. Some of those may be as important to the control of health care costs in Canada as the social insurance single payor system itself.

There are many factors that contribute to the success of the Canadian health care system. Single payor is but one of them.

The Canadian system of government is the most notable. It is a parliamentary system of government. Responsibility and accountability rests with the Minister of Health in the respective province, as health care is a provincial responsibility. The minister not only makes policy, but implements it as well. That individual must publicly defend the actions of the ministry before the provincial parliament. Laws are passed because the party in power wants them passed. Through party discipline, the prime minister or provincial premier generally prevails in

achieving his or her political goals. Party discipline is relaxed in few instances where members are allowed to vote their consciences.

The government controls not only the health system, but the education system which prepares new physicians and other professionals at the undergraduate, graduate, post-graduate and residency levels. It also controls the licensing system. In several provinces, there have been significant reductions in residency and medical school openings. In Quebec, there are restrictions on the number of physicians on hospital medical staffs. Some provinces have placed restrictions on where new physicians may open practices, or on the amount of reimbursement when physicians choose to settle in areas judged to be over-doctored.

No such parallel authority exists in this country. While Congress or state legislatures pass laws, it is up to the administrative branch to implement those laws. No clear focus of responsibility or accountability exists for performance of existing programs, let alone a program as complex as the a single payor system envisioned in current proposals.

Portability of Benefits and Reimbursement. In many areas of Canada, there has been a trend toward regionalization of governmental services—education, police, fire and transportation, to name a few. Canada has many urban areas, but none crosses provincial boundaries with the exception of the area of Ottawa, Ontario and the area of nearby Hull, Quebec.

Compare this to the United States. The urban area of Washington, DC crosses political borders

of three states. The New York metropolitan area encompasses three states. Some would contend that the area from Boston to Washington is a single urban area. There is significant interstate use of health services in these and many other areas.

Single payor systems tied to state boundaries are politically feasible but may not adequately address issues of regionalization and specialization across state boundaries. Portability of benefits and reimbursement become important issues to contend with. What happens to a person living in Virginia and working in the District? Or someone living in Moline, Illinois who needs special services available only across the river in Davenport, Iowa? Should the New Jersey government be allowed to restrict hospital investment as a cost control measure and encourage people to go to New York for treatment? Will Massachusetts physicians and hospitals be required to accept New Hampshire rates as payment in full? These problems will exist.

Canadians don't typically leave their province for health care. When they do their provincial plan is supposed to be portable, meaning it is obligated under law to pay for services in other provinces. While generally true, this Federal law is not enforced. A resident of Quebec treated outside of Quebec for routine or emergency care, is reimbursed at Quebec rates. Quebec rates are 30-40 percent below those of other provinces. The patient is responsible for the difference.

Patient Expectations and Liability. An example from Japan will illustrate yet another concern about drawing from other countries without understanding the context within which the health system operates. In May 1989, the Chicago Tribune reported on a lawsuit filed by a patient's

family in Japan against the patient's physician. The woman in question was diagnosed with gall bladder and liver cancer. Her physician told her that she had gallstones.

The woman died. Her family sued the physician on the grounds that had she known that she had cancer, she would have agreed to surgery.

The Court ruled that the physician had no obligation to fully disclose information which he or she feels may be harmful to the patient. The article went on to say that in Japan, cancer is considered to be almost always fatal, and physicians do not tell their patients about the presence of the disease as it will destroy their will to live.

Consider the implications of that decision within an American context. We have ever-increasing expectations of treatment and cure ("the magic bullet"), along with a growing insistence on informed consent and information on the range of treatment choices. Armed with a diagnosis, a patient can go to any number of physicians in multiple specialties looking for "the cure" for their problems.

Physicians in this country are armed with a growing number of medical, surgical and pharmaceutical treatments available to combat and cure disease. Combining this with fears of malpractice litigation would create an increased volume of medical services provided at tremendous cost to the system. This example demonstrates the cultural subtleties about health care in another country and the potential folly of the United States adopting a foreign system

whose success depends on certain cultural assumptions.

Returning to Canada, malpractice cases are heard by judges, not juries. In addition, cases are not taken on a contingency basis and a losing plaintiff must pay the court costs of the defendant. Lawyers are discouraged from taking cases other than those they are likely to win.

Citizen Expectations of Government. People in other countries look to their governments for a different range of services and functions than do Americans. In Canada, there are crown corporations--private companies owned by government. They exist to fulfill a government goal in addition to producing a product. These include broadcasting, transportation and utilities. These corporations are often in competition with privately-owned companies. Government has owned aircraft manufacturers, steel mills and other businesses seen as vital to the economic health of a region or particular industrial sector.

In Europe, one can look at the development of Airbus and the Concorde as another model. In France, banks owned by the government play a major role in owning industrial companies in France and other European countries.

These models of government participation in the economy have been an anathema to most Americans. It may also explain why government involvement in health care in other countries is easily accepted.

Putting aside the cost and technical details of a single payor health system (and these are not insignificant details), the essential question is how much government involvement do Americans want in the health care they receive. The polls, focus groups and media stories produce very mixed messages, which are not sufficient on which to make a major change to the delivery and financing of health care at this point. A Flint, Michigan man recently participating in a focus group on national health insurance indicated he liked the idea of national health insurance, but didn't want the government involved.

Recommendations for Market-based Reform. In the past few years, a major revolution in the delivery and financing (Integration, incentives for efficiency, and risk-sharing) has begun as a result of the efforts of employers and local business coalitions. This movement toward a competitive marketplace is occurring without government intervention. Even small firms are benefiting from this revolution. For example, the Timber Operators Council uses the collective resources of over 400 Northwest and northern California wood products companies to provide medical benefits to workers and their families. Together with five similar groups in that region, this organization covers nearly 90,000 employees and dependents in over 950 companies in many different industries. Administrative costs have been kept between 6 and 10 percent.

A health reform plan should build on these initiatives and foster new ones. To guide us in developing a plan toward this end, we recommend the following:

1. **Employment-based System and Employer Participation.** We support universal coverage that builds on an employment-based health care system. Required employer participation may well be considered if the final package emerging from Congress makes overall sense in terms

of affordable benefits, sound financing, adequate employer flexibility, reasonable limits on government intrusiveness, effective cost and quality controls and an end to cost-shifting to business.

2. Government Responsibility. Government should equitably finance its health programs to discourage cost-shifting to the private sector. Government should adopt marketplace principles for its own program beneficiaries by adopting efficient cost management and quality goals that emphasize managed care and incent appropriate consumer behaviors.

3. Provider Responsibility. Providers working with purchasers should continuously improve the value of health care dollars expended. Providers should use outcomes research and practice guidelines, make data available to assist purchasing decisions and actively participate in managed health care systems to achieve a quality-based system.

4. Purchasing Groups. Health care purchasing groups should be established to assist small firms and individuals to increase their buying power in obtaining affordable coverage. These groups should be purchaser-driven, promote competition and innovation in health care delivery and cost-management, be private not-for-profit, nongovernmental, non-regulatory bodies and be kept to a manageable size to assure that the group does not become a monopoly purchaser in the marketplace.

5. Multi-State Employers/ERISA. Any reformed system must continue to permit: (a) employee benefit plans to operate under a uniform ERISA framework and; (b) multi-state employers to operate under a uniform federal legal framework that precludes state benefit mandates, mandatory participation in state single-payer systems, the imposition of special state data requirements or state taxes to fund health reform, excessive reserve requirements or discriminatory surcharges; system reforms affecting multi-state employers must encourage innovation in benefit design, cost containment and quality improvement.

6. Insurance Reform. Insurance market reform is essential to assure that all employers and individuals can purchase health insurance irrespective of the health of the individuals in the group, either at the time of initial purchase or later on. To remedy this, insurance reform should eliminate the use of underwriting and preexisting condition restrictions. Such reforms should improve the availability and affordability of health coverage for small businesses and individuals, in particular.

7. Cost-shifting. A reformed system must be equitably financed to end cost-shifting. All types of cost-shifting must simultaneously be addressed. This includes cost-shifts to the private sector from government, to the manufacturing sector from non-manufacturing sectors and, within the manufacturing sector itself. We also oppose the imposition of strict spending limits applicable only to certain programs like Medicare and Medicaid, that would shift costs to the private sector.

8. Cost Containment. System reform must aggressively aim to reduce the rate of cost increases throughout the health care marketplace, including unnecessary and inappropriate care

delivered by and prices charged by service providers, administrative costs, and inappropriate utilization of services by consumers. Incentives must be included to encourage providers, purchasers and consumers to be more efficient.

9. Financing. Any financing mechanism should result in American manufacturing strengthening its competitive position in the world economy. Because access to health care is a concern and responsibility for all of society, in both the private and public sectors, any financing should not disproportionately impact any one segment of the economy. If additional revenues are necessary, financing should come from broad-based taxes, rather than from cost-shifting from the public sector to private employers.

10. Medical Liability. Strong medical liability tort reforms are needed, which should include uniform standards for medical liability claims—limits on non-economic damages in jury awards, periodic payments for large damage awards, limits on attorneys' fees, mandatory offsets for collateral sources and stricter statutes of limitations. The scope of such reforms should include liability for medical products as well.

11. Administrative Reforms. Efforts must be made to reduce administrative costs both for private medical plans and government programs, and for providers and individuals. Reforms in the private sector should include streamlining claims processing (for example, moving to a single claims form) and reforming regulations for Medicare and Medicaid, which often have spillover effects on private health plans.

Mr. WAXMAN. Dr. Bristow, let me ask you what I asked Dr. Freedman a few minutes ago, why you seem to take such different approaches even though you are both representing groups of physicians. She indicated that she thought H.R. 1200 freed the physician from crushing administrative duties, gave patients new latitude in choosing a physician. And you also recognize that preserving patient choice and physician clinical autonomy will help facilitate necessary access within the context of universal coverage. You acknowledge these principles of physician choice and autonomy under H.R. 1200, but you still oppose the legislation. Why?

Mr. BRISTOW. As I pointed out in my comments, Mr. Chairman, we believe that H.R. 1200, if implemented as written, would tend to stifle innovation, and it would certainly discourage excellence in the practice of medicine. That is for a very simple and we believe very obvious reason. It has a fixed global budget. It has fixed fee schedules for physicians, without balance billing.

Now those things fly in the face of the fact that physicians do not all have the same expenses in acquiring their basic knowledge or in carrying out the practice of medicine. The rent paid by me may be vastly different from a colleague just across the street. The expenses that I put into paying for my office help may be vastly different, if I want high-quality help, from that of another colleague.

And so to have a system which says we have got a fixed budget, a fixed fee schedule and there is no balanced billing, makes no allowance for physicians trying to be more accommodating to their patients, trying to bring better expertise to the problems. And, therefore, that, in our view, takes away the stimulus for innovation, for convenience and things of that nature, sir.

Mr. WAXMAN. What if there were not this global budgeting that set out so specifically the finite amount of money that would go into the system? If there were negotiation between a single-payer system or any system and what the physician would get by way of reimbursement that would recognize some of these costs, would you feel more comfortable with that kind of a system? Or do you find, as Dr. Freedman indicated, that much of their time as a physician is lost to administrative duties spent justifying treatment to private third parties, insurance companies that second guess their clinical judgment. And under which kind of a system would you think doctors would have a greater autonomy and ability to exercise their best professional judgment without interference?

Mr. BRISTOW. I think what would be important—let me address those in sections.

I think it would be important to recognize that physicians are very willing to sit down with government either at the State or Federal level and to negotiate a prospective target that would encompass within that not only demographic changes and the CPI but also the terrain as far as disease, what is likely to be required in terms of technological advances and what the likely demands of the population will be. Once those are set, then if there is a failure at the end of that next year of physicians carrying out their part of the bargain then certainly let's sit down and discuss that.

But, as you are well aware, H.R. 1200 does not do that. H.R. 1200 is silent on the matter of physicians being able to negotiate. So those would be important first steps to take along that line.

Mr. WAXMAN. How comfortable are you with the idea of doctors having to deal within a world of competing plans that negotiate with alliances and those plans, of course, would then negotiate with the physicians?

Mr. BRISTOW. We prefer to have as little bureaucracy as possible. We believe that we can accomplish the sort of goals that we all have with much less bureaucracy.

Let me cut to the chase and point to the far west, beyond our State to Hawaii. They have been able to do that by saying to the private sector these are the goals that we want to achieve in our State. We will set up rules to make sure that it is a level playing field. Now private sector has to figure out how to do it.

They have done it remarkably well. They certainly could have improvements on it. I believe that is what government should do, those things which the people cannot do for themselves: create a level playing field, identify the goal and then step back and let the private sector accomplish it. I think we can.

Mr. WAXMAN. Thank you very much.

Mr. Franks.

Mr. FRANKS. Thank you, Mr. Chairman.

Dr. Bristow, you had mentioned that the key issue is cost versus quality. And you had also mentioned that, ideally, we should look at ways in which we can slow the growth of the spending via competition. I wonder if you can expand upon that.

Mr. BRISTOW. Well, we believe that the system as it currently stands—as we have said, the status quo is unsettled. We cannot stay where we are now. Competition, as we have had it up until now, has not been effective, and we agree with that. We believe it can be made effective, however, by making sure that patients have price information which they currently don't have, by making sure that we use the new resource-based RVS which provides accountability from the profession's point of view and by making sure that physicians have an opportunity to participate in the decision-making that goes on in any sort of integrated health care entity.

It is of critical importance that we have some antitrust relief, gentlemen, in order to allow physicians to see to it that medical decisionmaking remains in the hands of patients and their doctors in the examining room, as opposed to having those decisions controlled by either large corporate entities or by bureaucrats.

Mr. FRANKS. Thank you.

Having worked in the manufacturing environment for roughly 10 years and having seen some of the changes where companies have now implemented gymnasiums within their facilities and various other programs, you had mentioned earlier, Mr. Huard, that the incentive for companies to truly participate in controlling health care costs would be diminished significantly if we adopted H.R. 1200. Could you expand upon that, please?

Mr. HUARD. Certainly. There wouldn't be any incentive at all. Basically, the government would tell the employer, cough up 8.4 percent of payroll or such other higher number as eventually would bubble up to the surface.

Under the current system, the employer is providing the benefit. The employer has an incentive to provide the best possible benefit at lowest possible cost.

Now, we have, you know, case histories of employers with relatively small work forces, 150, 200 employees, who buy gymnasiums, wellness programs, emphasis on educating their employees on the importance of healthy life-styles, preventive care, have actually lowered their health care costs over the last 10 years and are providing, frankly, better health care than would be provided in the administration's plan—I haven't looked at the schedule of benefits in H.R. 1200, to be candid—and at a lower cost than that plan would estimate those benefits to be generally available.

We think the genius of the private system—it lets employers innovate. It lets them use creative techniques, whether it is deductibles or co-payments, to make their employees more cost conscious. Not all of these creative techniques are at the expense of employees. Obviously, things like deductibles and co-payments are. Education on the importance of a healthy life-style, providing gymnasium facilities, wellness programs, these are things that the employer does. They don't cost the employee anything. All they have to do is participate in them, and over time they do reduce health care costs.

Mr. FRANKS. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Franks.

Mr. Hastert, I think you were there.

Mr. McMillan.

Mr. McMILLAN. Thank you, Mr. Chairman.

Let me focus on one thing, particularly in view of a report the Health Insurance Association of America released yesterday.

What is the implicit cost per capita in H.R. 1200, Congressman McDermott's plan? I can take the total estimated health care costs and divide it by the population, and I believe it is somewhere around \$3,500 per capita. That has probably got some things in there that aren't health care, that are health expenditures, that fall out of the line of reimbursement for services. But I believe your study indicated that. The President's plan has an implicit per-capita cost of around \$1,932 per capita.

Mr. KAHN. We think that is too low on the—actually, the President has four different categories, and our estimates ranging from 30 percent too low to one of the family categories being as much as 67 percent too low.

We approached our estimate in a different way. They looked at national health expenditures and divided the number, and our actuary did an actuarial estimate where he looked at what actuaries generally look at, which is health expenditures based on claims, and sort of built up from the bottom the numbers.

Mr. McMILLAN. So versus the \$1,932, you have a figure of \$2,509.

Mr. KAHN. Right. So we think that the premium that has been estimated by the administration is lowballed a bit.

Mr. McMILLAN. What are the implications of that? For example, one of the controversies is underestimating the cost of entitlement programs, Medicaid and Medicare to be specific. And the Clinton

budget estimates are according to our calculations, very far off. I don't mean to focus on Clinton, but I think we are really talking about an assumption of a far greater portion of health care costs in the Federal budget. If you make an error of roughly \$600, \$600 per capita, in the estimated costs of the Medicaid that would be paid into an expanded subsidy into the regional health care alliances, what is the magnitude of that on the Federal budget? Would you have a quick estimate of that?

Mr. KAHN. I wouldn't necessarily have an estimate, but I think it will have a reverberation effect throughout the entire program. Let me explain.

Mr. McMILLAN. It goes into the mandate that—

Mr. KAHN. There is a capped 5789 so the Federal Government might be somewhat protected if the estimate is wrong, but the money to pay for those benefits has got to come from someplace or the health alliances are going to have to get it from the employers to cover the amount that the government is short.

Mr. McMILLAN. But the government sets the price under the plan so that if the price is \$1,932, then the mandated payers, be they individuals or corporations, are stuck with that ceiling price so the health care alliances run a shortfall, right? And then what happens?

Mr. KAHN. Then there is a big problem, and the health alliances—

Mr. McMILLAN. Then they come to back to the underwriter of last resort, which is the taxpayer, as we were in the case of the savings and loan industry once we took the lid off the deposit insurance.

Mr. KAHN. As I was going to say, there is a reverberation effect because if you lowball the premium in the first year and then in the outyears you only allow a less-than-inflation-rate increase so that you are down to zero real growth by 1998, then you have got real problems in terms of financing fiscal integrity of the whole system.

Mr. McMILLAN. We have undertaken, as you may know, to see what the cost of a voucher plan would be that would provide universal access and affordability equivalent to the President's proposal, but it would operate through an individual mandate, and those vouchers would only be spendable for an acceptable plan.

But the critical thing was costing it out. We went to independent actuaries, and we had a set of benefits that weren't that different than what are normally considered to be standard basic benefits in the industry. And the cost per capita of that worked out to be \$2,250 per capita, which is slightly under yours and a little bit more than the President's plan. That would be including Medicare in it—I mean, including the senior citizens into that average.

Now, if you add to that a long-term care program, you add about \$250 to \$300 on the average, spread over the population, which would give you a way to perhaps bring the senior citizens into such an insured program.

And the amazing thing is that when you extend this out all the way up to 400 percent of poverty on a scale-down basis from 100 percent of poverty you can fund it within the outlays of Medicare and Medicaid that we pay today. It is really amazing which I think

would do all those things, that bottom line the President says he wants, but preserve choice and a competitive response.

But I wanted to zero in on those comparison cost estimates because I think they are critical, and the President in his plan has dramatically underestimated the cost.

Mr. KAHN. That is a concern our actuary has. At least in terms of premium they are understating the amount, and he would argue it is the way they calculated it. That is the reason they came up with the number they did.

There are other studies. Hewitt and Associates have done a study, and we are at about 4 or 5 percent higher than their study, but we are in the same ball park so we have real concerns.

Mr. McMILLAN. Lewin is the most favorable study, and it is still 15 to 20 percent.

Mr. KAHN. It was about 17 percent more than theirs.

So if you match the premium being lowballed with the possibility that the premium caps over time won't be applied, the fiscal integrity of his program is questionable whether you come up with the money to fund the benefits that are being promised.

Mr. WAXMAN. Thank you.

Mr. McMILLAN. Thank you very much.

Mr. WAXMAN. Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. Huard, your association represents a—rather larger manufacturers and some smaller manufacturers in this country. When you compare—you are testifying on the single-payer bill today. When you compare what is available to you in this country as compared to what happens to your counterparts in Canada when you look at, say, one province, Ontario, that I happened to visit with two of our people giving testimony this morning, Mr. McDermott and Mr. Conyers—

Like I said, it is like the blind man trying to tell what an elephant is. It is different things to different people.

But I spent a day in looking at the books on the province of Ontario and it was of interest because there was a comparative in Illinois, 10 million people in Ontario and 11 million in Illinois. They spent \$1,750 for every man, woman and child in Ontario. They have a marginal income tax that helps pay for health care that is 39 and 59 percent. They have a 15 percent value added tax on all goods and services, and there was about an \$800 employer check-off.

That was a year ago. I don't know if it has changed or not for every employee in that country. They brought in in that revenue stream \$7.5 billion. There was a shortfall of \$10 billion in health care.

How does that affect what you seize in long-term planning? I mean, somebody has to make up for that. Somebody—either you have to raise the premiums, you have to raise taxes or you have to cut down on services. And that is basically what they did in Canada last year. They cut services.

So I am going to direct the question, same kind of direction, to the gentleman from the AMA. But how do you see that as—can you comparatively compete? Is that an advantage? Disadvantage? How do you see that?

Mr. HUARD. You know, from our standpoint it would be a terrible impediment to trying to plan and make any kind of a business plan. That looks bad because, basically, you would really have no basis for estimating what your cost increases are going to be because, basically, you have no control, at least in the current situation, where, admittedly, health care costs are rising faster than we like to see them.

Employers who basically design and provide coverage for their employees have a variety of options. One of these options is increasing deductibles. Another option is increasing the co-payment, increasing the amount of premium shared with the employee. So you conduct various planning scenarios, and you can at least get a reasonable idea, looking into the outyears, of what your costs for health care for your employees are likely to be.

You can't do this under a Canadian-style system or under the kind of system you have in H.R. 1200 because, basically, all you know is that the premium rate is 8.4 percent of payroll this year. What it is going to be next year is basically what the government decides it could get away with politically to cover its shortfalls.

Frankly, you know, that makes planning any kind of a rational business planning extremely difficult because you, basically, have no control so you have no basis for planning.

Mr. HASTERT. Dr. Bristow, with your members in Canada there is a cap for general practitioners—I think \$125,000. If a doctor earns more than that figure, he or she is penalized. I think for specialists the cap is about 400 and some thousand dollars and a penalty on top, but they practice inside hospitals, and some of their costs are tied into that. Do you see this as a system of built-in rationing? How does that work? How do you think your members would react to that?

Mr. BRISTOW. Well, we think that any system which relies primarily on a broad-based governmental tax tends to insulate the user of that health care system from the consequences of their decisions. And we think, in fact, that will tend to be inflationary. It will tend to make people use more. A certain amount of that is good, obviously. We want people who are not using the item to use it appropriately, but that is an important feature.

However, the more important one is that type of system, in our view, removes the individual's ability to set their own priorities as to the importance of health care. And that, we believe, is going to be very, very troublesome. It is a little bit like saying we have decided that one breakfast cereal will suit all Americans. However, the cereal is oatmeal. We have—

Mr. HASTERT. Quaker Oats likes that, incidentally.

Mr. BRISTOW. Pardon?

Mr. HASTERT. Quaker Oats likes that, and they have held down their health costs for the last 5 years.

Mr. BRISTOW. That is exactly right. We are concerned about a one tier of care, as has been mentioned by other witnesses, for all Americans. Americans, I believe, are fairly well united that we must make sure that all Americans have access to and coverage for a certain basic amount of care. But I am concerned about limiting the amount of care that you can get to that one tier. We usually like to feel that if I want to, as an individual, set my priorities to

get something better for me or my family that I should be able to do that.

When you have a single-payer system, it becomes extremely difficult to do so. The people in Canada achieve that by leaving the country. That is a little difficult to do. And I am not knocking Canada. I really am not.

What I am advocating is that there are many features in H.R. 1200 that are excellent features. We support them. We would like to encourage consideration of a different way of financing in order to achieve the goal.

Mr. HASTERT. Just a quick follow-up, Mr. Chairman.

When you look at the preamble to the Canadian Constitution and the preamble to our Constitution, we talk about life, liberty and the pursuit of happiness. The Canadians talk about law, government and order. So there are different priorities there.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert.

Mr. Huard, you said that the NAM has not taken any position on the bills. What is your organization's view or your members' view, as best you know, about the idea of eliminating the deductibility for businesses for health insurance costs above the lowest-priced HMO?

Mr. HUARD. Well, the representation on limiting deductibility on any formula is quite negative. Our basic view is that tax deductions for business taxpayers are not subsidies. Basically, they are the appropriate means of determining net income, which is your gross income from sales and other receipts less the cost of doing business.

And this idea that somehow there is this cash cow that can be tapped by saying you can only deduct 50 percent of business meals and you can only deduct X percent of this and Y percent of that and while we are at it we are going to cap your deductions for providing medical benefits for your employees which is, frankly, is just a form of compensation, is something we object to under any circumstance.

If the goal is to induce cost consciousness, then the appropriate place to put a cap is on the exclusion where the employee receives all these benefits tax free. If you want to make the users of benefits cost conscious, then you don't cap the employer deduction. You cap the users.

Mr. WAXMAN. I think you are right. Because if you are really talking about the theory of giving the consumer a reason to want to shop around, which would make the plans more competitive, you would have that consumer pay more rather than just, say, the consumer's employer would to pay more taxes.

But Mr. Cooper in his bill didn't do that. He would take away the tax deductibility for businesses. I guess one would have to figure that the way that translates into making the consumer more sensitive is that the employers would say, well, if all I can deduct is the lowest-priced HMO I am not going to provide any more benefit than that, and, therefore, my employees would have to pick up the difference.

The only thing that would make some sense to me, in order to get to that result which you and I both acknowledge, is the one

that you would have to have in order to drive the competitive market forces system. But it doesn't do that.

Mr. HUARD. No. I would say candidly Mr. Cooper has it backwards. If he was going to put a cap, he should have put it on the employee side, not the employer.

Mr. WAXMAN. It seems to me that a lot of employers, because of collective bargaining or because it is good business sense, in order to make their employees happy are going to want to provide something more than the lowest-priced HMO.

Dr. Bristow talked about single level of care. I don't find it attractive to say that we are going to lock people into a single level of care which is going to be the lowest-priced HMO in our society. So is it your position that you are against that part of the Cooper bill which goes against the deductibility?

Mr. HUARD. Yes, indeed.

Mr. WAXMAN. Well, it is an interesting proposition to say to the American people what we are going to do is lock you into the lowest-priced HMO unless you pay more money. One could argue it is in their interest, but I am not sure they are going to see it in their interest if that is what Congress does at the end of the day in order to bring about market forces. How confident are you about market forces working if we ended up with that?

Mr. HUARD. I am certain, based on our own experience—confident that, properly designed, they can be made to work.

We used to have an indemnity insurance plan. I have been with the NAM for—since the early 1970's, and for many, many years we had an indemnity plan. That was it. We had one plan. And like a lot of employers we found that our costs were just going crazy through the ceiling so we put in, basically, a choice of plans where people can go in through an HMO which is the lowest cost. They can go into a preferred provider type of plan so they can have an indemnity plan. And there are different prices at different costs.

Some of the plans—the one I am in, which is the preferred provider option, has deductibles and stop limits that are based on compensation. So the higher-compensated employees like me pay more for this plan than the lower-compensated employees.

Mr. WAXMAN. That is your own experience as an employee at the NAM.

Mr. HUARD. I think it works.

Mr. WAXMAN. Mr. Kahn, what is the Insurance Association's position on the idea of eliminating tax deductibility in order to make the marketplace more competitive?

Mr. KAHN. We think it would be a useful change in the tax law. We don't have a specific level or limit or methodology in our policy, but we do believe that changing the tax exclusion would make a difference in terms of consumer sensitivity to costs.

Mr. WAXMAN. What do you think of the idea of eliminating the tax deductibility for the employers only?

Mr. KAHN. We don't have a specific policy on the method of doing it, but our preference would be on the employee side.

Mr. WAXMAN. All right. Thank you.

I don't know, Dr. Bristow, if you want to add any of your views on this subject.

Mr. BRISTOW. Mr. Chairman, I was simply going to say that we support the idea of limiting the tax deductibility for the employer, but it would certainly not be at the level of the lowest HMO in the community. We would support choosing a much more intermediate level that is consistent—reasonably consistent—with the median of today's benefit level and then if the expenses are beyond that, that the employer's deductibility be capped at that point, and those additional expenditures would be taxable income to the employee. But our level would not be at the lowest HMO.

Mr. WAXMAN. And that is because you don't want to force people into the lowest-priced HMO?

Mr. BRISTOW. Yes.

Mr. WAXMAN. So you really want to give them more of a choice.

Mr. BRISTOW. Exactly.

Mr. WAXMAN. Well, it was interesting—Mr. McDermott made the comment to start off the hearing today that he thought that the idea of the Cooper bill is a hidden tax increase on middle-class people, especially if their employers don't continue to provide insurance coverage as they now do. Because they are only going to provide it for what is deductible, which is the lowest-priced HMO, which is, of course, what drives the market forces best because people then would pay out-of-pocket for their health care and understand if they are paying for it they want to be better shoppers.

There is an argument to it. It is pretty much untested. And maybe the American people would accept it if they found it worked, but I think for a while they would be pretty unhappy while they are waiting to see whether it works. Because if the result is that we pass a bill where they immediately have a big increase to pay for what they already have, my experience is that is not really good politics.

Mr. Hastert, do you have anything you want to add?

Mr. HASTERT. Just a little bit for the gentleman from NAM, Mr. Huard.

Let's lay out a parameter and what I think you are saying, what you think this country needs and certainly your constituents would like. You talked about—and you can give this answer in the affirmative or negative—is malpractice reform, good tough malpractice reform. You think our current system drives costs in this country?

Mr. HUARD. Yes. Our estimate is that lack of malpractice reform is probably adding 10 to 20 percent to costs.

Mr. HASTERT. How about antitrust reform so hospitals and care providers can share ideas and hold down overutilization?

Mr. HUARD. I don't know that is an area in which we have cost estimates.

Mr. HASTERT. Do you think there ought to be portability of health care from job to job? That people can move from job to job and not be locked in?

Mr. HUARD. I think that there is probably widespread agreement amongst our members as well as amongst the general public. One of the more desirable things to have is portability and limits on the applicability of preexisting conditions clauses.

Mr. HASTERT. Let's follow up. Then you think we probably ought to limit the ability of insurance companies to underwrite on the basis of an individuals preexisting conditions?

Mr. HUARD. I think that, yes, I would agree. You are going to have one of those insurance reforms in order to reach those goals of security, portability, affordability, the smaller employer groups.

Mr. HASTERT. Let's talk about small employer groups. In some research we have done, we have seen that most of the people out there, other than people who are underserved and below 200 percent of poverty, those folks are small business people and people who work for small businesses, not necessarily your counterparts but the smaller businesses, pretty marginal businesses.

And the reason they don't have insurance is when they go to the market they are going to have to pay two or three times the amount that somebody pays for insurance when they work for a business like—such as most of your members. And how do you get those people into a situation where they can buy good insurance at low cost and get tax deductibility just like any of your businesses?

We talked about this. I think that is a fair and equitable issue out there. So if you think—if you found ways to do that, that would be a major step forward.

Mr. HUARD. I think that is right. I think that is one of the major improvements that could be made in the existing system, without prejudging the issue of whether it has to be done through huge health alliances or single-payer programs or programs at the other end of the spectrum which use vouchers or provide tax credits or tax deductions. These insurance reforms get rid of preexisting clauses.

Providing for community rating or portability can be done under any of the systems that are floating around out there and would be a major step forward in solving a lot of problems. Obviously don't solve all of the problems. You still get the problem of achieving universal coverage. But they would solve a lot of problems of affordability for small businesses, access for small businesses, and these are major problems of the—

At one point in my career, I ran a two-man law partnership with one secretary. You try to get health insurance coverage for three people at a reasonable price. You can't do it.

Mr. HASTERT. But there are ways that you could probably pool and get low-cost coverage or self-insurance at a low price.

Mr. HUARD. You have to look around a lot.

Mr. HASTERT. I said, if you could set the market up that way—anybody can respond to this. We have seen a tremendous response in the private sector. I mean, companies that you mentioned, the oatmeal company—and that was made in jest.

But Quaker Oats has, for instance—example—used wellness programs and those types of things and held their health care costs under 5 percent for 4 years in a row because they are doing aggressive action, making sure that their employees are healthier and working towards that and doing a tough job of negotiating, incidentally, with their insurance carriers or their self-insured systems.

Hospitals are capitating budgets and—you know, instead of building hospitals for 500, we are building hospitals for 150—and doing other things that are cost-effective.

Do you think those types of parameters are important to be included for a health care bill?

Mr. BRISTOW. I would love to see the ability to have a level playing field so that physicians could also meaningfully participate in those discussions and negotiations. I think that would be absolutely wonderful.

You mentioned liability reform before. Let me just give you a quick illustration of how important that is. Twenty years ago, when MICRA was passed in California, I was paying \$4,000 a year as an internist in the Bay area. My counterpart on Long Island in New York was paying \$4,000 as an internist. Twenty years later we have had MICRA. I now pay \$5,500 a year. My counterpart on Long Island pays \$18,000 dollars a year.

That is what MICRA means. It is a substantive savings just in the liability premiums themselves, let alone the pressure it relieves as far as defensive medicine is concerned.

Mr. HASTERT. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Hastert.

And I want to thank the three witnesses. You have been very helpful. We appreciate you being here.

That concludes our hearing this morning, and we will come back here at 1:30.

[Whereupon, at 12:28 p.m. the subcommittee recessed, to reconvene at 1:30 p.m. the same day.]

AFTER RECESS

Mr. WAXMAN. As we resume our hearings on the alternative health reform bills this afternoon, we will turn our attention to H.R. 3080, the Affordable Health Care Now Act introduced by the distinguished Minority Leader, the Honorable Robert Michel of Illinois; and accompanying the minority leader will be our colleague on the committee, the Honorable Dennis Hastert of Illinois, and the Honorable William M. Thomas of California, member of the Committee on Ways and Means.

We are pleased to welcome you to our hearing. It is an honor to have the Minority Leader, especially, to come. And we are not used to having Mr. Hastert as a witness, but we are pleased to have him. And Mr. Thomas, a fellow Californian, we are pleased to have you here, as well. Your prepared statements will be placed in the record in full. You may proceed, however, you see fit.

Mr. MICHEL. Thank you. And I appreciate the opportunity to present the case on behalf of H.R. 3080.

Mr. WAXMAN. Mr. Michel, before you begin, I want to yield to Mr. Bliley, who is the distinguished ranking Republican member of the subcommittee.

Mr. BLILEY. Thank you, Mr. Chairman. I just want to welcome our leader, whom I have had the privilege of working with over the past 2 years on his task force early in the mornings, I might add; and late in the evenings. And with Bill Thomas, as well as Dennis, I think what we have come up with is a very credible plan.

Everything in it has been tried and proven, and it is something that can be done now while we work on some of the more intractable and more difficult things in the future.

And with that, I yield back the balance of my time.

Mr. WAXMAN. Thank you, very much, Mr. Bliley.

**STATEMENT OF HON. ROBERT MICHEL, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF ILLINOIS**

Mr. MICHEL. Mr. Chairman, and members of the subcommittee, this is a product of our Republican Task Force on Health that we established as far back as 1991, long before the President came into office. In other words, we on the Republican side have been studying and working on the health care issue for quite some time. We have had numerous town hall meetings in our districts. We have met with many individuals in all walks of life. We have a good idea of what the problem areas are in our health care system and how the people want these problems fixed.

We currently have 140 cosponsors of H.R. 3080, more than any other proposal in either body of the Congress. And our efforts in developing the proposal reflect the strong view of Republicans in the House that reform of our health care system is essential and should be enacted as soon as possible.

There is, however, a right way and a wrong way to reform our system, and in this regard we have a fundamental philosophical difference with the President. The President believes that to make health insurance available to those without it, we must radically restructure the insurance plans of everybody else, including those who are perfectly happy with what they have. We believe that affordable insurance can be extended to the uninsured and underinsured without undermining the coverage and the quality of care of the insured.

The President is proposing a government-run health care system. We think that having the government run one-seventh of our Nation's economy would be disastrous for health care in America.

The President believes universal coverage should be imposed upon the people by forcing them into a government-run health care system. Our view, on the contrary, is we pave the way to universal coverage, but we leave the decision in the hands of the people.

The President would give us the choice of only one benefit package to be determined by Washington. We believe, on the other hand, that people should have the choice of a variety of different benefit packages in order to best meet their own individual needs.

The President believes that the way to cost containment is through federally-imposed spending caps on health care services. We believe that any such spending caps would lead to fewer services rationing, delays in care and less technological advances.

The President believes that imposing a significant tax increase on employers is the way to finance health insurance. We know that such a tax increase, by the administration's own admission, will cost hundreds of thousands of jobs. We believe that providing health insurance for some at the expense of jobs for others is not the right way to do it.

Finally, the President believes that his entire reform plan with all the additional benefits he would provide will cost no more than what is raised through a cigarette tax, a tax on employers that is capped at 7.9 percent, and reduction in funding for Medicare and Medicaid. We believe that this is sheer fantasy.

The history of Government programs shows that they always exceed their initial cost estimates many times over. This Member was here at the time we enacted Medicare/Medicaid back in the sixties.

Yes, and also during our ill-fated attempt at catastrophic health care. So when these costs exceed what the President is counting on, the result can only be substantial tax increases or significant cut-backs in coverage.

Our proposal is a common sense approach to health care reform. It focuses on fixing the shortcomings of our health care system, not overthrowing the entire system simply because some of the parts are not working right. It proposes workable reforms that will make things better for people now, not risky, untried concepts that will likely not be implemented until after the turn of century. It builds upon and encourages many of the reforms already under way at the State and local level and in the private sector, not negate these reforms through the imposition of a government-run health system imposed from the top down.

Last night it was my good fortune to meet with 15 of our 18 Republican Governors, the Republican leadership, House and Senate, and I can tell you, the exchange of views by those Governors and earlier in the day, their exchange with the President, I think indicates that there are all kinds of questions to be raised out there on the part of the Governors before they would ever think of buying in with the President's proposal.

Before turning to my colleagues to discuss the details of our proposal, let me issue this cautionary note: you all—and I just alluded to it a moment ago, recall our ill-fated attempt at catastrophic health care a few years ago. I was one of the lead sponsors of the proposal, thinking that with a nominal Medicare premium we would alleviate or at least minimize that fear that all of us could have at one time of suffering the fate of a heart attack, stroke, Alzheimers, you name it, where your whole house, family, or farm and all your assets are dissipated.

And, of course, you all know the story of how we had to repeal it a year later because of the outcry of many of our senior citizens. In my district, I guess I got most of those complaints from retired Caterpillar workers who were fully covered and objected to paying for others who were not. As we get into the debate this year and I look at the 80, 85 percent of the people out there who are reasonably satisfied with what they have by way of health care, but who are going to be forced to pay for those 15 percent who have a real problem in the area, it is not going to be all that easy to get that done because we have been through it before, and we ought to be very careful how we proceed.

If that limited outcry on catastrophic by one segment of our population was sufficient to cause most Members to admit a mistake, just wait until you see the size of the outcry if we do not do the reform of our overall health care system in the right way. And if there is an inclination on the part of leadership in Congress to ram through a massive overturning of our entire health care system in the rather limited time we have available this year, there almost certainly will be major errors and miscalculations that will rebound negatively on this institution. When we start to monkey around with one-seventh of our Nation's economy and something that affects every American, we had better be darned sure we do it right.

Health care is too important to the American people for us to be making mistakes. As I indicated, our bill, H.R. 3080 provides a

common sense solutions to the problems that most Americans want addressed.

I am happy to yield to my colleague, of this committee, Mr. Hastert, and then later we will hear from our other colleague who serves so ably and capably on the Ways and Means Committee, that shares in no small measure the jurisdiction that you folks do on this committee.

Mr. HASTERT. Thank you, Mr. Leader, and Mr. Chairman. I certainly appreciate the opportunity to testify before you and your committee today.

My remarks will focus on the steps that our bill takes to increase access to affordable insurance and health care for millions of Americans. Our reforms acknowledge that the uninsured are not a homogeneous group; rather, people do not have insurance for a variety of reasons. And our reforms seek to address those specific reasons.

First, many of the uninsured work for small businesses. As you probably know, small businesses face several disadvantages when they enter the health insurance market. Most insurance companies are not interested in covering them precisely because they are small.

Small companies today not only begin with higher premium costs, but if one person in their small group gets sick, they are likely to see a large premium increase the next year, and that sick person, the person with the preexisting condition, knows that they will have a difficult time getting health insurance if they change jobs.

To address that problem, we reform the small group insurance market along the same lines of Senator Bentsen's bill that had been considered in the Senate just a year or so ago. We require insurers to offer three plans if they want to operate in the small insurance market and no longer will they be allowed to exclude people or charge exorbitant fees because of preexisting conditions.

We also take steps to make it easier for small employers to pool together for the purpose of purchasing health insurance. Our bill establishes standards for multiemployer insurance purchases groups, and we eliminate the current IRS regulatory barrier which prevents employer groups from being able to offer tax exempt health insurance.

This would allow groups such as the National Restaurant Association or the American Farm Bureau to offer health insurance to all their members, basically the smallest mom and pop organizations that we have in our economic structure today. And finally, we exempt all group health plans from State benefit mandates and State restrictions on managed care. We believe these reforms will lower the cost of health insurance for those small employers who are currently priced out of the market.

The President's plan requires all employers to pay for their employee's health insurance. Our plan acknowledges the reality that small businesses operate on a very thin profit margin. Thus, we require employers to offer—offer health insurance to their employees.

While we believe many small employers will help to pay some of the cost of the premium for those employees who do not, we give 100 percent tax deductibility to those individuals who buy their

own health insurance and because their company can offer insurance that is pooled with others, employees will benefit from the large group rates.

So, in essence, what we are trying to do is to give the same breaks to small employers and their employees that any other business gets. That is a small, low cost insurance, a quality insurance that has tax deductibility across the line. We also increase the tax deductibility for self-employed from 25 percent to 100 percent.

Our bill recognizes that many of the uninsured are low income individuals who do not qualify for Medicaid and the working poor. We provide States with the flexibility to extend Medicaid coverage to more of the uninsured while working with the private sector to bridge the gap between Medicaid and employer-provided insurance.

Our bill allows States to redirect Medicaid funds into what we call health allowance programs where eligible individuals would be able to enroll in private market health plans. We give States the option of increasing eligibility up to 80 percent of the poverty level.

States would have the option of setting up a sliding scale whereby individuals up to 200 percent of poverty, that is a working couple with a family of four at \$28,000 or less, could buy into the health allowance program.

States could also develop pooling mechanisms that all other families and individuals without health insurance such as part-time workers, early retirees, et cetera, could join what we call accessible health benefits systems for the purposes of buying health insurance.

And finally, we give States the flexibility to enroll Medicaid beneficiaries into HMO or PPO plans.

The Affordable Health Care Now Act also increases funding for community health centers to increase access to primary and preventive care and we enact reforms to ensure that those living in rural areas would have access to quality emergency care. We also tackle the problem of long-term care.

We provide the same tax benefit for long-term care insurance as for other insurance plans. We give Americans the options of using IRA's, 401(k) plans or life insurance tax free to purchase long-term care insurance, and we allow States to offer senior asset protection plans so that seniors will no longer have to choose between spending down to the poverty level or hiding their assets.

In essence, we also try to establish a continuum of long-term care so people who choose in-home health care and then in nursing homes and finally if they choose the hospice care, have that availability and opportunity.

These provisions have broad bipartisan support and should be enacted quickly. Moreover, 75 to 80 percent of the uninsured would be helped immediately. They wouldn't have to wait for a Federal or State bureaucracy to be established.

Once the remaining uninsured are identified and the reasons why they are uninsured are discovered, targeted solutions can be developed to provide them coverage, possibly by 1998.

I thank you for the opportunity and hopefully would answer any questions you may have.

Thank you, Mr. Chairman.

STATEMENT OF HON. WILLIAM M. THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMAS. Thank you, Mr. Chairman. It is a pleasure to appear before you and I would like to outline the provisions in the Michel bill designed to eliminate wasteful spending in the health care system and reduce cost. And I would ask unanimous consent that my written statement be placed in the record in its entirety.

I would like to talk about the provisions for cost control in the backdrop of the recent numbers coming out of Bureau of Labor Statistics which clearly show a distinct pattern. In 1993, medical price inflation was 5.4 percent. In the fourth quarter, it was 4.4 percent.

When you compare that with the previous year, 1992, at 6.6; 1991, 6.6; and 1990, 7.9, there is a clear trend of a downward direction in medical price inflation and I think that is important as a backdrop in discussing cost controls so that we are not focused on the problems of the late 1980s, but in fact we are focused on the concerns that I believe are paramount in terms of cost control in 1994 and 1995.

Although we applaud the downward direction of medical costs, it seems to me that it is nothing but a positive sign that we don't need the strict controls in the President's plan. But it doesn't mean that we can't make additional cuts in areas that are wasteful and unnecessary.

First, I think the Affordable Health Care Now Act would eliminate excessive regulations and unnecessary paperwork. Everyone has talked about the need to simplify and standardize. We believe you should standardize claim forms, preempt State laws which hinder the electronic transmission of claims and other records, and provide consumers with information on the comparative value of medical services. This education and information function, I think, is critical to long-term savings.

Second, the Affordable Health Care Now Act would provide an exemption from antitrust laws to providers who enter into a joint venture to increase efficiency, expand access, reduce cost and eliminate excess capacity, as well as share high technology equipment or medical services.

Mr. Chairman, such an exemption, which is more expansive than the one included in the President's plan, would enable providers to coordinate efforts to provide the highest quality of care in the most cost-effective manner. These people are health care professionals and should be allowed to professionally address the health care problem.

The Federal Government has stood in the way of the private sector for too long and many areas have suffered either through reduced access or excess costs.

Third, the Affordable Health Care Now Act would discourage frivolous malpractice claims. It would limit malpractice awards, eliminate the need for defensive medicine, all of which clearly have added unnecessarily to the cost of health care in the United States. The bill achieves this by requiring the use of an alternate dispute resolution system. By capping noneconomic damages. By limiting contingency fees. By limiting liability to participation in a harmful act and by directing punitive damages to the State for the purpose of reducing medical malpractice.

Once again, Mr. Chairman, these reforms go far beyond those reforms proposed by the President, but go to the heart of one of the key problems in the health care area and are long overdue.

Fourth, sorry to admit it but I think it is true, fraud continues to be a problem in our health care system. Billions of dollars each year are fraudulently billed to insurance companies, taken from consumers, and the government as well. Current law is simply not adequate to prevent fraudulent activity.

The Affordable Health Care Now Act would enhance the FBI and the Inspector General's office at the Department of Health and Human Services in their efforts to detect, investigate any of the fraud activities that are out there, especially staying current with more of the newer and more innovative techniques. It is a full-time job. The bill also protects whistleblowers and provides them with rewards if information leads to prosecution.

The act permits private insurers to deny reimbursement to providers who commit fraud, just as the government does. It allows for the forfeiture, after conviction, of property either involved in a health care fraud scheme or obtained with the proceeds of such a scheme. These reforms are needed and they can be passed today.

Finally, the Affordable Health Care Now Act provides consumers with the option of opening a medical savings account, commonly called a medi-save account. These accounts would allow consumers to make the health care spending choices they and their doctor believe are most cost-effective for them. They also reward consumers who use health care dollars prudently by allowing them to roll over any left over funds in the account to be used solely for medical expenses in the next year or succeeding years.

The most crucial element to controlling costs in the health care system, in my opinion, is to get the consumer more involved. The current threshold question of "Will my insurance cover it?" has to be replaced with the informed dialogue between the patient and their doctor about the efficacy and cost of a procedure.

With the information and education supplied by this simplified administrative structure, medi-save accounts, I believe, will help consumers be more informed and participatory in their health care decisions, thus reducing their health care costs. It may not be a universally applicable system, but it is clearly one that would lead the way in stressing the importance of the education of each and every consumer.

The cost control provisions in the Affordable Health Care Now Act are designed to address the current spending problems—the 1994 and 1995 problems—found in our health care system, not the ones from the late 1980's. These reforms can be accomplished now. In fact, they could have been accomplished last year, bringing much needed relief to American consumers.

I urge this subcommittee to pass these core changes now so that we can continue the downward trend in medical price inflation.

I thank the chairman.

[The prepared statement of Mr. Thomas follows:]

Statement of the Honorable
BILL THOMAS
Member of Congress, 21st District of California

before the
Committee on Energy and Commerce
Subcommittee on Health and the Environment

February 1, 1994

Mr. Chairman, thank you for the opportunity to address the Subcommittee today and discuss the health care reform bill developed and introduced by the House Republican Task Force on Health, the Affordable Health Care Now Act of 1993. In particular, I would like to outline the provisions in the bill designed to eliminate wasteful spending in the health care system and reduce costs.

The issue of health care spending has been in the news as of late and cost controls will be one of the most contentious parts of the upcoming health care reform debate. The Bureau of Labor Statistics recently reported that medical-care prices rose just 5.4% last year, the smallest increase since 1973, and the fourth quarter increase was only 4.4%. In fact, reports show that medical prices have been on a steady decline since 1990 with rates of 9.6% in 1990, 7.9% in 1991 and 6.6% in 1992.

Although the current downward trend in medical-care price increases is a positive sign and demonstrates that the strict cost control measures included in the President's plan are unnecessary, it does not mean that further cuts in wasteful spending are unnecessary.

The cost control measures included in the health care reform plan developed by the House Republican Task Force on Health are

the result of almost three years of study into health care spending in the United States and addresses the current spending problems. Most importantly, these measures could be passed today and take effect immediately, and they would not result in a reduction in the quality of care currently enjoyed by Americans.

First, the Affordable Health Care Now Act would eliminate excessive regulations and unnecessary paperwork, which greatly increase the cost of providing health care in the current system. The Act would standardize claim forms, preempt state laws which hinder the electronic transmission of claims and other records and provide consumers with information on the comparative value of medical services.

Each of these provisions would streamline the provision of care in the United States, thus saving providers and consumers millions of dollars every year.

Second, the Affordable Health Care Now Act would provide an exemption from antitrust laws to providers who enter into a joint venture to increase efficiencies, expand access, reduce costs and eliminate excess capacity, or share high technology equipment or medical services. Such an exemption, which is more expansive than that included in the President's plan, would enable providers to coordinate efforts to provide the highest quality of care in the most cost-effective manner to all areas of the United States. The Federal government has stood in the way of the private sector for too long and many areas have suffered -- either through reduced access or excessive costs -- for too long.

Third, the Affordable Health Care Now Act would discourage

frivolous malpractice claims, limit malpractice awards and eliminate the need for defensive medicine, all of which add unnecessarily to the cost of health care in the United States. This is achieved by requiring the use of an alternative dispute resolution system, capping noneconomic damages, limiting contingency fees, limiting liability to participation in the harmful act and directing punitive damages to the State for the purpose of reducing medical malpractice. Once again, these reforms go beyond those proposed by the President but they go to the heart of the problem and are long overdue.

Fourth, fraud continues to be a growing problem in our health care system. Billions of dollars each year are fraudulently billed to insurance companies and taken from consumers. Current law is not adequate to prevent fraudulent activity.

The Affordable Health Care Now Act would enhance the Federal Bureau of Investigation and the Inspector General's office at the Department of Health and Human Services to detect and investigate fraud and the bill protects whistleblowers and provides them with rewards if information leads to prosecution. The Act also permits private insurers to deny reimbursement to providers who commit fraud, just as the government does, and allows for the forfeiture, after conviction, of property either involved in a health care fraud scheme or obtained with the proceeds of such a scheme. These reforms would greatly reduce health care fraud in the United States, and they can be passed today.

Finally, the Affordable Health Care Now Act provides

consumers with the option of opening a medical savings account, known as a MediSave account. These accounts would allow consumers to make the health care spending choices they and their doctor believe are most cost-effective. They also reward consumers who use health care dollars prudently by allowing them to rollover any leftover funds in the account to the next year.

The most crucial element to controlling costs in the health care system is to get the consumer more involved. The current threshold question of "Will my insurance cover the procedure?" must be replaced by informed dialogue between the patient and their doctor about the efficacy and cost of the procedure. MediSave accounts force consumers to be more informed and participatory in their health care decisions, thus reducing health care costs.

The cost control provisions in the Affordable Health Care Now Act are designed to address the current spending problems found in our health care system, not the ones found in the health care system of the late-1980s. These reforms can be accomplished now, bringing much-needed relief to American consumers, and I urge the Subcommittee to pass this legislation this year.

Mr. WAXMAN. I want to thank the three of you for your testimony. I know you put a lot of work into it. And we do have disagreements, which I hope sometime during this year we will be able to bridge, if possible, but in order to make health care insurance affordable, which is what you claim in your title, Affordable Health Care Now Act, we have got to do something about the cost increases in health care, spending.

It is interesting to note that the Department of Commerce estimated over the next 5 years health care spending will increase at an average rate of 13.5 percent per year. That is just not going to be affordable. And what I would like to know is since you oppose the combination of managed competition and backup limits on premium increases, how you would restrain cost increases?

We are going to hear later this afternoon from the National Leadership Coalition on Health Care Reform, and they represent some of the large employers, unions, providers and consumer groups; they are going to say your bill won't keep spending increases inbounds and they urge the use of targets and rate-setting for fee-for-service providers.

Could you tell us precisely how your bill will protect business and workers from a 13.5 percent increase in the foreseeable future each year?

Mr. HASTERT. I think that is a great question. I think it is very important and right to the point.

I think you have to look and say, what has driven cost increases in medical delivery? Part of it is technology. We have a system today that is more technologically advanced than we had 10 years ago or 20 years ago or 30 years ago, but yet it is something that people demand and if we are going to keep the best health care out there, we have to have the R&D and the technologies that go along with it.

But we find so many times that there is an overutilization of that technology. For instance, I had a conversation with one of the chief surgeons at Rush St. Luke Hospital in Chicago, one of the larger institutions, and he was talking about what happens in standards of practice. And almost any time they do an orthoscopic surgery for a torn meniscus on the knee, they use an MRI. They don't need to, but it is part of the standard of practice and you are liable if you don't and are called into court.

So we think malpractice is a cost driver. It is a cost driver in two ways. When you look at what the cost of insurance is, if you are an OB/GYN in my district and deliver a child, 8 percent of that cost up front is just the cost of insurance.

The other side of that is are the cost drivers, for example, when someone has gallbladder surgery. A doctor can give you up to \$5,000 or \$6,000 worth of tests, not to make you well quicker or for a prognosis, but just to make sure that if they are hauled into court they have done the procedures, A, B, C, D, E and F. We think that good solid malpractice reform is important.

The other side of that is how do you work around antitrust. How do you get health care delivery groups to cooperate? Why does every hospital—at least in my district, we have 5 hospitals within a 30 mile radius—why does every one of those hospitals need an MRI, an orthopedic lab, a pulmonary lab, a cardiac lab?

They must cover not only the cost of capital but also the operating expense. Why can't communities cooperate?

We try to address that so that you don't overutilize it and what happens with doctors and hospitals many times they overuse that facility just to pay for it because you have got to spend down the capital costs.

Mr. WAXMAN. How do you get them to coordinate the use of their resources? Through the elimination of antitrust?

Mr. HASTERT. Absolutely.

Mr. WAXMAN. Don't you think that there is a competitive drive for all the hospitals to have this equipment?

Mr. HASTERT. Part of it is the antitrust law. The law today forces hospitals to compete. That is what the law says. And as soon as they start to cooperate, they are liable in a court of law. So we are saying let's change that law and make it easier for the hospitals and health care providers across the board—to work together.

Mr. WAXMAN. OK. I thank you very much.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Thomas, did you wish to expand on that?

Mr. THOMAS. Well, I will only speak from my position as the ranking Republican on the Health Subcommittee on Ways and Means; we have been sitting through a lot of hearings as well. One of the reasons that I led off with the Bureau of Labor Statistics was because the price inflation numbers show a clear downward direction since 1990 from 9.6 to 5.4 percent this last year with a fourth quarter showing a dramatic drop. I am looking forward to the first quarter of 1994 and the second quarter of 1994.

I think you are going to find this trend is continuing. One of the frustrations that we have is taking today and extrapolating it to tomorrow. We don't have the ability to fold into our budget process human behavioral changes.

We should not commit the same error in our understanding of these numbers. Frankly, the private sector, from the bottom up rather than the top down, was as scared by those 13.5 percent figures as we are trying to deal with the public good. They have changed their behavior. California, as you well know, Mr. Chairman, is now a managed care State. It wasn't 5 years ago. People are changing their decisions. We are providing them with the tools.

And if you want to praise the President and the First Lady for anything, it should be in elevating this issue to the point that everyone is now focusing on the problem. We are not the only ones focusing on the problem. And I do not believe that those numbers are realistic. I believe structural changes are beginning to take place on the initiative of individuals and especially States.

Look at the last 2 years the changes that have been made in the States. Once again, California, I didn't think that in our lifetime that the trial lawyers and the medical industry would get together and pass a malpractice reform law. They did it. It is a good model. Dr. Stu Altman in a discussion that I had with him agreed that the changes that are taking place are probably structural and, therefore, will have lasting effect.

And the last thing, Mr. Chairman, we should do is continue to take numbers from 4 and 5 years ago on an extrapolation of then

costs and try to change the system to match those numbers. Let's look at today's numbers and tomorrow's numbers and make the adjustments accordingly.

We do not need the fundamental drastic reform that the President has called for. The American people are ahead of the United States Congress and the States are ahead of the United States Congress. They have been making changes within the areas that they have been able to make changes.

We need to enable, open up and provide opportunities for these changes to continue. Those are the kinds of very simple, long-lasting cost control changes that will bring about significant change in the cost of health care.

Thank you.

Mr. BLILEY. Mr. Michel, Bob, and you, Denny, you know, one of the things that came up over and over in my visits at home in town meetings was concern about preexisting conditions, concern about portability, concern about renewability, and would you explain for the benefit of the committee how H.R. 3080 addresses those three?

Mr. MICHEL. We address all three of those very fundamental concerns. We knew that we were, in effect, going to have to come down a bit on the insurance industry and say look, you have got to take a different view of this. We cannot be credible by having a predetermined exclusion, we have got to be all inclusive.

And how many times have you and I heard the stories of people trying to move up to a better job but are so fearful of making a move to another job because they can't take their health insurance with them and it is not available at the other end.

We provide for that and I think it is fundamental that we do that.

Mr. BLILEY. Thank you.

Mr. WAXMAN. Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

I would like to focus in a little bit on what it is that the various bills that are under consideration require of employers. For starters, the Clinton bill obviously has employer mandates; the Michel bill does not.

Could you give us some insight as to what it is you think is negative about the employer mandate? What do you think the downside consequences would be of a Clintonesque employer mandate?

Mr. THOMAS. Number one, all of the testimony that we have received clearly would indicate a churning in the marketplace. One of the difficulties I have is assuming that employers are not now, especially on a time line trend, taking more responsibility in terms of health care costs. They are. But they are not at the President's 80 percent level. They could be at the 50 percent level. Some are attempting to move up.

If you mandate an 80 percent level, there is going to be a significant ripple through all the employment structures, primarily at the bottom of the structure, the minimum wage and slightly above, of having to meet a mandated health care cost; it clearly will lead to loss of jobs.

That makes no sense to me when the requirement is to provide health care coverage, employer-structured, by removing people from their employment position. That will happen. No question. So

not much at the high end. There will be an adjustment and belt tightening.

At the low end, you will hear testimony from service corporations, large service corporations that hire at close to the minimum wage that there is no question that there will be a loss of employment if an employer mandate like that proposed by the President is imposed.

The President also in the State of the Union, I would tell my friend from Pennsylvania, did not necessarily say that it had to be an employer mandate. He said he wanted guaranteed private health insurance. It didn't have to be by an employer mandate. If the people will look at the dynamics of the employer mandate, it is a much more Draconian process of providing this coverage than perhaps other options.

Frankly, from the testimony that I have received in front of my subcommittee, I do not understand the requirement that it be imposed on the employers, when everybody knows, business gets its money from three places. It doesn't grow on trees. It either comes from reduced profits for owners, an increased price for the goods or services to the customers, or it comes from the employee. And studies show that over the last 20 years, 85 percent of the time it comes from the employees. The employees are going to pay ultimately for any employer mandate.

The downside of the employer mandate is you spend \$10 to \$15 billion in the Department of Labor to set up a structure to enforce and oversee the employer-paid premiums when, in fact, you are duplicating what is already going on in the Internal Revenue Service. It makes no sense for the purpose of moving money when it doesn't have to be collected that way in the first place. Two primary problems: loss of jobs and a whole new bureaucracy to do what somebody else could already do.

Mr. GREENWOOD. We trade in the problem of people with jobs and no health care for a problem of people with health care and no jobs.

Mr. HASTERT. If you analyze the market out there, who doesn't have health care today, and you will find that 85 percent of the people do. When you boil those numbers down, the hard core 16 to 18 percent of the people who don't have health care, most of those people either are small business folks, they are mom and pop grocery stores on the corner, barbers, beauticians, truck drivers, farmers, people that run and own their own business, because when they go to the market with one or two people to take to that market they are paying anywhere from 150 to 300 percent what the other person gets his insurance for when he works in a bigger company, a company over 50 employees, for instance.

If you are making \$30,000 a year and you have to pay \$9,000 for you and your wife's health care insurance, you are just priced out of the market and you can't afford to do it. Those people deserve the opportunity to get the same break that everybody gets and that is low cost pooled insurance, quality insurance, and get a tax break on it like everybody else does.

The same goes for people who work for small businesses. Mostly small businesses that are shops of 10 or 15 people that are marginal, startup businesses, they can't get low-cost insurance because

their employer doesn't provide it. We say that there has to be a mandatory offered people, they get choices of three different types of policies and they are low cost and they get tax deductibility when they get it. We are talking about a family over \$24,000 a year.

People want to do the right thing. People do not buy insurance because they don't want to buy insurance. We think people don't buy insurance because they can't afford to buy health insurance. Make it affordable and accessible. And we give people an incentive to do the right thing.

Mr. WAXMAN. Mr. Moorhead.

Mr. MOORHEAD. Thank you. I want to join in welcoming our leader today. One of the things that many, many people in my district are concerned about is that senior citizens are going to get the short end of the stick with the Clinton program because much of the program is paid for by cutting back the money that is available for Medicare. What are differences between the two plans about the way they handle all senior citizens over the age of 65?

Mr. THOMAS. Briefly, the President's plan indicates that they are going to be provided with a prescription package that they do not now have. However, the overall guaranteed benefits package for those under 65 will be far richer than the Medicare package for the seniors on a comparative basis. My concern in dealing with the seniors is to focus on where the President finds a significant portion of his money.

We will know either later this week or next week whether the numbers fit. I am curious to see whether they do. The President has said that they are going to fund their program with a \$124 billion reduction in Medicare—\$73 billion coming out of the hospital structure, \$24 billion of it will come from beneficiaries themselves. There are going to be higher costs for the same services within that structure.

The other thing that I think that Medicare beneficiaries should understand is that the President's long-term health care program is not a program under the Medicare structure. There has been some confusion and I am sure some of your seniors are confused as mine were, assuming that long-term care is going to be part of a Medicare program.

That is not the case. And so, when you examine the President's program, one of the things that I think was a real lost opportunity was to really provide a health care package for all Americans. One of the things we try to do in ours is to mainstream all recipients.

Instead of running a separate program for the seniors and another program for the nonseniors, we believe that everyone ought to have the same coverage. And the goal in ours is to move everyone around the same structure and not run separate tracks.

Mr. MOORHEAD. The testimony that we heard was that the President's program is underfunded by someplace between \$50 and \$100 billion. In the event that happens, what happens to senior citizens and to others that are dependent upon the President's plan for providing their medical care?

Mr. HASTERT. Well, we are moving from our plan to the President's plan, but clearly one of the problems that we have and one of the fears that we have is that Medicare will end up being a

ghost, something hollow. You are carving \$50 billion, two new entitlements that are not basically paid for, and so what you do is push people out of Medicare, something they know today and have paid for and the premiums are set into a program of benefits that they are going to have to buy into if they want real health care in the future. We, in our program, really don't address that.

We think that Medicare is something that seniors have today and they are comfortable with it and we don't change that. But we want to put the same cost constraints all health care across the board and try to hold down those rising Medicare costs, because we think that they will respond to the market forces as well as everything else in the private sector.

We would like to keep this in the private sector as much as possible. But clearly in the President's bill you carve out the funding for Medicare and what you end up with are the people who are providers who get less, have less, and ultimately offer less, and that is the real fear with the President's program, and seniors.

Mr. MOORHEAD. Under our bill, are there people that will not be covered or is there something provided for each—some kind of health care provided for every American?

Mr. MICHEL. In the lower income—one of the ironies of the current system that you have low income working people getting less than people on straight Medicaid. That is a real irony.

We recognize that these people in this strata ought to be especially taken care of by way of giving the States, for example, an opportunity to opt for 200 percent poverty level and then buy in voluntarily into an insurance program that would cover them all with some of the basic benefits. So I think from that standpoint, it has always been a problem area for us.

And I tell you, again, last night the Governors were very apprehensive and you think all the problems of Medicaid and our being taken to the cleaners by the States themselves when they didn't think we should have been at the Federal level because it is a shared role and responsibility.

When they look at what we might be doing here by taking away, when they hear the President say we are going to finance this all with Medicare and Medicaid. That leaves a void. And it has got to be filled and those Governors out there say we are the ones eventually who have got to address this problem at that local level. And they have real apprehension about it.

Mr. HASTERT. If I could just add to that, Mr. Chairman. One of the real problems when you get down to it, in Illinois a family of five on AFDC basically gets their health care in an emergency room. The average cost in Illinois is \$15,000 a year to take care of that family of five because every time a kid has a sniffle or the flu or bronchitis, they don't go to the doctor's office because they can't get into a doctor's office. We need to get those people primary care, preventive medicine at a lower cost; and we need to have the incentives to redirect those dollars to make sure that those people get good care instead of when they are really sick in an emergency room and we think we have those strategies to do that.

Mr. WAXMAN. Well, I thank you very much for a presentation of your bill.

Mr. MICHEL. Thank you, Mr. Chairman, for your time and that of the subcommittee.

Mr. WAXMAN. Our next panel includes Mary M. McGeein, vice president, National Council of Community Hospitals; George J. Pantos, Washington Counsel to the Self Insurance Institute of America; and Harry Sullivan, senior vice president for public affairs and general counsel to the Food Marketing Institute.

We welcome you to our hearing today.

Without objection, your prepared statements will be placed in the record in full. We would like to ask if you would limit your oral presentation to no more than 5 minutes. We have to be quite strict about the 5-minute rule in order to be fair to all the witnesses.

Ms. McGeein, why don't we start with you?

STATEMENTS OF MARTY MCGEEIN, VICE PRESIDENT, NATIONAL COUNCIL OF COMMUNITY HOSPITALS; GEORGE PANTOS, WASHINGTON COUNCIL, SELF-INSURANCE INSTITUTE OF AMERICA; AND HARRY SULLIVAN, SENIOR VICE PRESIDENT, FOOD MARKETING INSTITUTE

Ms. MCGEEIN. I understand my time is limited, so I will talk rapidly.

Thank you for the opportunity to testify before you today.

As you have said, NCCH is a membership organization that represents the interests of the not-for-profit, community-based hospitals, their patients and the communities they serve. This year is the 20th anniversary of NCCH—and this is only relevant if you understand that NCCH was founded as a result of hospitals' experience with previous efforts to impose wage and price controls on the health care system.

NCCH, since its creation, has emphasized the need for meaningful and effective reform of the health care system. We are not newcomers to this task, to its complexities, its pitfalls and its unintended consequences.

In particular, we have repeatedly stressed that meaningful health care reform, reform that will change health care for the better, is local and must proceed from the bottom up. Communities as a whole must be given the power, the authority and the incentives to work together to develop delivery mechanisms and systems that will most efficiently and effectively provide care to all members of the community. Government help is necessary. Government control is not.

For years people have come before you and this committee to tell you how best to solve discrete health care problems facing various populations. These problems are oftentimes solved with programs that, though well-meaning, never address the system as a whole because the system is exactly that. It is a system. And changing a single piece of it creates a cascade of complex and often unpredictable changes throughout the entire system.

Single, targeted programs have given us nurse practitioners in the Mississippi Delta who receive a higher rate of reimbursement for office visits than do doctors of medicine and osteopathy. It has given a system in which poor women go to two, three, four or more places to receive their health care—with each place taking a part

of the single problem. It has given us Medicaid mills, unfortunately.

In each of these instances, programs were designed at the Federal level in a one-size-fits-all format. While solving those problems, we created others. If we are going to have true health care reform, we need to recognize regional and local diversity, and we need to recognize that, for a majority of the United States population, the system is working well.

President Clinton has had the foresight, the passion and the pure courage to set reform in motion, and we sincerely commend him for this. NCCH believes that reform is a process. It occurs in steps or stages over time. The reformed system is not the goal. The measurable improvement in the community's health is the real goal. That is the one we should hope to achieve.

Reform requires community innovation and creativity. Most importantly, government financial assistance should not bring in its wake government control of each community's health care delivery system.

We are pleased with the path which is taken by H.R. 3080. The Affordable Health Security Now Act of 1993 starts us in the right direction by emphasizing the localness of our current system while beginning to work on fixing its multitudinous problems. We must go further, but it is an excellent beginning and an excellent base.

The approach taken by H.R. 3080 builds upon the current system and makes it possible for more people to participate in it and the system itself to make the changes necessary for improvement of health. We believe it would be totally wrong, as a starting point, to change the entire system for all Americans to cover the uninsured.

Our patients and communities are best served by a system that encourages insurers and providers to compete on a basis of quality and price, a system that encourages local innovation and collaboration. H.R. 3080 guarantees that individuals will be able to get insurance regardless of health status and will be able to take it with them when they change jobs. It absolutely releases the lock of job lock.

These are essential reforms, and we are pleased to endorse them. The bill begins the process of extending coverage on a step-by-step, realistic basis. This is necessary to reach our goal of universal access to resources and to care that will improve the health of all. For we must reach this goal, but we must do it in a way that is cost-effective and delivers improvement in health, not in more health care.

The administration's bill, on the other hand, would severely restrict the role of private markets and turn allocation decisions over to our government. We must remember that reform is empowering and encouraging each health care delivery system, not constraining it. The government should not be making a political decision on how much money should be spent on health care. That is up to the people. The role of government is to ensure that the market is efficient.

Shall I continue or shall I stop?

Mr. WAXMAN. Do you want to make a concluding statement?

Ms. MCGEEIN. Yes. We support H.R. 3080 as an efficient first step. We, obviously, would like to see total control of the health care system at the local level. We won't get that, but we certainly are appreciative that our time has finally come for reform.

I thank you for your time.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Ms. McGeein follows:]

TESTIMONY OF
THE NATIONAL COUNCIL OF COMMUNITY HOSPITALS

Thank you for the opportunity to testify before you today. I am Marty McGeein, Vice President of the National Council of Community Hospitals. I am also a nurse with special interest in maternal and child health, a mother, and a very concerned citizen. Concerned because reforming the health care system is not a trivial matter and should be undertaken with only the best interests of the nation at heart.

NCCH is a membership organization that represents the interests of not-for-profit community hospitals and the patients and communities they serve. This year is the 20-year anniversary of NCCH. This is relevant when you understand that NCCH was initially founded as a result of hospitals' experience with a previous effort to impose wage and price controls on the health care system. NCCH was created by innovative leaders in the health care field who sought to find a better way to reform.

NCCH has, since its creation, emphasized the need for meaningful and effective reform of the health care delivery system. We have worked with Congress on reform proposals for most of our 20-year history. We are not newcomers to the task, to its complexities, pitfalls, and unintended consequences.

In particular, we have repeatedly stressed that meaningful health care reform--reform that will change health care for the better--is local and must proceed from the bottom up. Communities as a whole must be given the power, the authority, and the incentives to work together to innovatively develop delivery mechanisms and systems that will most efficiently and

effectively provide care to all members of the community. Government help is necessary; government control is not.

For years people have come before this committee to tell you how best to solve discrete health care problems facing various populations. These problems were often "solved" with single, targeted programs that never addressed the system as a whole. But the health care system truly is just that--a system--and changing a single piece of it creates a cascade of complex and often unpredictable changes throughout the entire system.

Single, targeted programs have given us nurse practitioners in the Mississippi Delta who receive a higher rate of reimbursement for office visits than do doctors of medicine; it has given us a system in which poor women go to two, three, or four places for their health care--with each place taking care only of a single problem; and it has given us Medicaid mills.

In each of these instances, programs were designed at the federal level in a one-size-fits-all format. While solving some problems, we created others. If we are going to have true health care system reform, we need to recognize regional and local diversity, and we need to recognize that for a majority of the United States population the system is working well.

Do we have a crisis in the health care system? We submit this is the wrong question and produces a wrong answer--whatever answer is given. A "crisis" produces a reform "solution." What is needed is not a reform solution--for a "solution" is not the answer. What is needed is a reform path--a reform process. That

process recognizes certain principles. That process recognizes present strengths and builds on principles and strengths over time. The President has had the foresight and the passion to set reform in motion. We must choose the right principles and the right path.

NCCH believes that reform is a process that occurs in steps or stages over time. A reformed system is not the goal. The measurable improvement in the people's health in each community is the real goal. For that is the outcome we truly want and need.

In particular, NCCH believes that it is critical that the economic and regulatory barriers that already prevent health care providers and patients from coming together and developing methods of providing care more efficiently should not be built even higher. They should and must be broken down. The need for health care reform should not be translated into the too-easy assumption that reform requires more government regulation.

Reform requires community initiative and innovation. It requires restructuring the delivery and financing system to permit private innovation to take hold community by community, and in their way to developing the most cost-effective, consumer-responsive health care system possible. Most importantly, government financial assistance should not bring in its wake government control of each community's health care delivery system either directly or indirectly. Just as the late former

Speaker often said that all politics is local--so, all health care is local. The path of reform must lead from this principle.

With this background, let me say that we are pleased that health care reform is being seriously considered, and we commend the President for this. At the same time we are pleased with the path which is taken by H.R.3080. The Affordable Health Care Now Act of 1993 starts us in the right direction by emphasizing the localness of our current system, while beginning the work of fixing its problems. We must go further but it is an excellent beginning and base.

The bill correctly rejects the idea that the government should be the allocator of resources committed to the health care delivery system and should control its many and multi-faceted components. Our patients and our communities are best served by a system that encourages insurers and providers to compete on the basis of quality and price, a system that encourages local innovation and collaboration.

The bill guarantees that the individuals will be able to get insurance regardless of health status, and will be able to take it with them when they change jobs. It releases the job lock. These are essential reform and we are pleased to endorse them.

By these reforms and limits in premium increases in the small employer market, the bill would make insurance more available and make it easier for everyone to obtain insurance.

The bill does not ensure that everybody will avail themselves of this opportunity or indeed that they can, but the important point is that it begins the process of extending coverage on a step-by-step, realistic basis. This is necessary to reach our goal of universal access to resources and to care that will improve the health of all those who live in this country, community by community. After reforms such as those made by H.R.3080 have had a chance to take hold, the country could determine to what extent and, more importantly, the reason why people still do not have insurance. This would permit a focused attack on whatever barriers remain. For we must reach this goal, but we must do so in a way that is cost effective and delivers improvement in health, not just more care.

The approach taken by H.R.3080 builds upon the current system and makes it possible for more people to participate in it and for the system itself to change to make the improvement of health its goal. We believe it would be totally wrong as a starting point to change the entire system for all Americans in order to cover the uninsured. The answer for covering the uninsured is changes in the way insurance works, an honest tax, changes in each local delivery system and vouchers to make it possible for the uninsured to participate in the system with dignity and choice as others do.

The Administration's bill would severely restrict the role of the private market and turn allocation decisions over to governments. It would employ a variety of mechanisms that would

bureaucratize and politicize the health care delivery system. Very personal and individual decisions would be made by members of a federal board, a state-controlled regional health alliance, and by state government. It does not take 1,364 pages to set the path of reform. And reform is not an all-seeing, all-encompassing blueprint in infinite detail. Reform is empowering and encouraging each health care delivery system, not constraining it.

Equally important, the Administration's bill would--to an absolutely unprecedented degree--criminalize the health care field by creating a whole panoply of "federal health care offenses." Reform will not happen if people who are delivering personal health care services and their patients are thought of and treated as criminals.

The Administration bill would also impose price controls on insurers, drug companies, and fee-for-service providers.

The premium caps are designed to effect an immediate and unrealistic reversal of long-term trends in health care costs. It is our belief and experience that this will require rationing of services to the elderly, as well as to all others, as plans shift the onus down to hospitals and doctors. Our organization has been here before.

Controls will scare capital away from the health care field, make it impossible to make the changes in the system that are needed, and thus deprive people of new technologies. Any short-term cost benefits will produce long-term nightmares.

The government should not make a political decision on how much money should be spent for health care. That is up to the people. The role of government is to ensure that the market is efficient and that the people can make the decision on economically unbiased factors.

H.R.3080 addresses forthrightly another important component of cost containment, malpractice.

Reform requires immediate changes in the medical malpractice system. We have not considered the restraints of managed care on patients' demands nor have we considered the determinations made by the courts. These pressures are a critical component of the increase in health care costs. Malpractice reform must include guidelines for care that would protect providers from suit as long as such guidelines are followed, and permit them to deviate where professional judgment believes that is appropriate. Guidelines will take time, effort and experimentation, but they are on the right reform path.

We support the focus in H.R.3080 on developing alternatives to litigation by encouraging Alternative Dispute Resolution (ADR) systems. We would suggest two ways it could be strengthened. The bill's ADR measures, in large part, would not reduce litigation; they would just add a new forum that must be exhausted before litigation, increasing the cost to the health care system as well as increasing the delay inherent in litigation. A claimant who loses in the ADR phase is not likely to be deterred from bringing suit by the possibility of paying

the defendant's attorneys' fees if he loses in court. The court is not, as a practical matter, likely to impose that sanction on an individual. The ADR system should be the end of the process--except in very limited cases (such as those in Federal Arbitration Act).

Also, we would suggest that the definition of eligible ADR methods be amended to include one that would even more dramatically reduce the amount of litigation . . . early offers.¹ The early offers approach encourages potential defendants to step forward to make the first move with offers in settlement of claims for non-economic loss and encourages patients to accept legitimate, fair offers. This would, where there was agreement, avoid litigation entirely. Much of the expense of the malpractice system is the conduct of the litigation system. Steps should be taken to reduce the amount of litigation, including those conducted by ADR, to the extent possible, and at the same time provide quicker and fair payment to the patients. We believe that the early offers approach would do so. The Administration bill does include early offers in its recitation of ADR methods and this is a part of the Administration bill which we support.

Conclusion

Reform is needed. But it is complex. Unanticipated consequences must be avoided. We support, therefore, reform that fixes the problem of the current system in a careful manner and does not overturn the entire system. H.R.3080 goes in the right direction. Thank you for giving us the opportunity to discuss it with you.

¹This approach was contained in a bill offered by Representatives Richard Gephardt and Henson Moore in the 99th Congress. We will gladly work with the appropriate committee on this approach.

Mr. WAXMAN. Mr. Pantos.

STATEMENT OF GEORGE J. PANTOS

Mr. PANTOS. Thank you, Mr. Chairman.

I am George Pantos, Washington counsel for the Self-Insurance Institute of America. On behalf of SIIA, I am pleased to offer comments today on H.R. 3080.

Like most groups, we recognize there are problems with the Nation's health care system and that changes are needed. We believe that all Americans should have equal access to quality health care and that escalating health care costs must be contained.

We agree with speakers on the first panel that President Clinton is correct to draw attention to the Nation's health care problems. However, we believe his health reform plan goes in the wrong direction and goes too far and would only serve to exacerbate the current health problems.

We believe the President's call for more government involvement in the health marketplace is the wrong prescription for the problems of soaring costs and limited access. Like the authors of H.R. 3080, we believe insurance reforms, small employer reforms, greater competition, enhanced choices, financial incentives rather than mandates, and other market approaches are needed to resolve current health problems.

We support open and free choice by employers to fund employment-based health benefit plans through the most economical means possible, including traditional insurance arrangements, self-funded plans or prepaid health maintenance organizations. The cost of the quality health care should be the responsibility of all participants in the health system including the consumers.

Today, I would like to focus my remarks on certain aspects of H.R. 3080. While not in agreement with all aspects of H.R. 3080, we welcome this proposal as a positive, constructive contribution to the current health reform debate. The bill provides an initial package of proposals which will contribute to establishing a more solid foundation for an improved health system.

We believe that many of the provisions in H.R. 3080 could and should be enacted on their own if Congress becomes bogged down in the overall issue of health care reform. We agree with the bill's objectives that employers must provide access to health care coverage for employees and their families.

We also believe the bill's small employer and insurance reform goals will help produce significant and much-needed improvements in the current health care system. The insurance reform proposal would eliminate preexisting condition limitations in health plans. It would require the inclusion of health benefit coverage regardless of health condition and guarantee the renewability of health plan coverage.

These important changes, which are widely supported, are needed to expand the availability of health coverage to those who change jobs and protect those with serious illness from health coverage loss or excessive increases in plan costs. The self-insurance community supports these changes as applicable to both insured and self-insured health plans.

H.R. 3080 requires insurers who sell on the small market to offer a standard health plan—as a matter of fact, three standard health plans—to all companies who employ two to 50 employees. This provision moves in the right direction because it builds upon the current employment-based system while addressing the need to expand access to essential health care coverage.

An expanded employment-based system of health care coverage with the employer as the purchaser of health benefits is essential to assuring the delivery of appropriate quality health care to all working Americans. The administration's call for an exclusive system of health alliances under State regulatory authority would, for all practical purposes, eliminate virtually all employers from their current role in purchasing health benefits offered to their employees. For this reason, we support the approach in H.R. 3080 of expanding access of coverage through small employer reforms rather than through a system of exclusive health alliances.

H.R. 3080 includes a provision made up of Federal incentives and standards for strengthening multiple employer purchasing groups. I refer to the much-needed MEWA reform provisions which would effectively regulate self-funded multiple employer arrangements, allowing employers to continue active participation in these health care arrangements.

While large- and medium-sized companies have been the leaders in self-insurance—and, by the way, I might add that two out of three participants today in group health plans are covered by self-insurance—industry statistics show this to be about 56 million employees with over 100 million participants, including dependents, paying over a total of \$100 billion in benefits in 1991 according to industry surveys. This is a very significant player in the current health system.

Thousands upon thousands of companies with fewer than 50 employees today are self-funding, and more are seriously considering this option. In addition, more than 5 million individuals and their dependents employed by small firms, firms with less than 25 employees, participate in a variety of self-funded, pooled health benefit arrangements which is sponsored by national trade associations and other business groups. But we believe this particular provision is a step in the right direction in opening up the door for multiple arrangements.

As for the regulatory system, we believe that health reform and cost reductions can only be accomplished through a national framework, and we support the approach that would allow for uniformity in the health care system in order to ensure a uniform environment for the efficient provisions of health care services.

So, in conclusion, Mr. Chairman, we believe that H.R. 3080 provides a viable framework for health care reform by addressing many weaknesses in the current health care system while preserving and enhancing its strengths, and we believe that H.R. 3080 builds on the present system and will encourage more competition as well as more choices for consumers and employees in selecting efficient, affordable health plans.

Mr. WAXMAN. Thank you, Mr. Pantos.

[The prepared statement of Mr. Pantos follows:]

STATEMENT OF
 SELF-INSURANCE INSTITUTE OF AMERICA, INC.
 to the
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
 ENERGY AND COMMERCE COMMITTEE
 U.S. HOUSE OF REPRESENTATIVES
 February 1, 1994

Mr. Chairman, members of the Subcommittee, I am George Pantos, Washington Counsel for the Self-Insurance Institute of America, Inc. (SIIA). On behalf of SIIA, I am pleased to offer comments on The Affordable Health Care Now Act (H.R. 3080).

The Self-Insurance Institute of America, Inc. (SIIA), is a national trade association serving the self-insurance industry. SIIA has over 1500 members -- representing over 60 million American workers -- and includes employers, third-party administrators, managing general underwriters, insurance companies, reinsurers and others dedicated to the advancement of self-insurance. SIIA is the only U.S. association that represents firms, individuals and organizations which participate in the broad spectrum of self-insurance, including the self-insurance of health benefits.

SIIA recognizes there are problems with the nation's health care system and that changes are needed. We believe that all Americans should have equal access to quality health care services and that escalating health care costs must be contained if health care is to be made affordable for all Americans.

While President Clinton is correct to draw attention to the nation's health care problems, we believe his health reform plan goes in the wrong direction and would only serve to exacerbate rather than to resolve many current health problems. The President's call for more government involvement in the health marketplace is the wrong prescription for the problems of soaring costs and limited access.

Insurance reforms, small employer reforms, greater competition, enhanced choices, financial incentives rather than mandates, and other private competitive market approaches are needed to resolve current health problems.

SIIA supports open and free choice by employers to fund employment-based health benefit plans through the most economical means possible, including traditional insurance arrangements, self-funded plans, or pre-paid health maintenance organizations. Open access to all provider networks should be made available by employers who sponsor health plans for employees and their families. The cost of quality health care should be the responsibility of all participants in the health system.

The Affordable Health Care Now Act

Today, I would like to focus my remarks on certain aspects of the Affordable Health Care Now Act of 1993 (H.R. 3080).

While not in agreement with all provisions of H.R. 3080, we welcome this proposal as a positive contribution to the health reform debate. This bill provides an initial package of proposals which would help to establish a more solid foundation for an improved health system. Many of the provisions in H.R. 3080 could, and should, be enacted on their own if Congress becomes bogged down in the overall issue of health care reform.

Insurance Reforms: We agree with the bill's objective that employers must provide access to health care coverage for employees and their families. We also believe the bill's small employer and insurance reform goals will help produce significant improvements in the current health care system.

The insurance reform proposal would eliminate pre-existing limitations in all plans, require the inclusion of health benefit coverage regardless of health condition, and guarantee renewability of health plan coverage. These changes -- which are widely supported -- are needed to expand the availability of health coverage to those who change jobs, and to protect those with serious illness from health coverage loss or excessive increases in plan costs. We believe these reforms will dramatically expand access to the health system for millions of Americans who do not now enjoy coverage.

Small Employer Reforms: H.R. 3080 would require insurers who sell in the small group market to offer a basic health plan to all companies who employ 2 to 50 employees. This provision moves in the right direction because it builds upon the current employment based system while addressing the need to expand access to essential health care coverage.

An expanded employment-based system of health care coverage with the employer as the purchaser of health benefits is essential to assuring the delivery of appropriate, quality health care to all working Americans. We believe the Administration's call for an exclusive system of health alliances under state regulatory authority would, for all practical purposes, eliminate virtually all employers from their current role in purchasing health benefits offered to their employees. The ability of employers to design and offer health plans which meet the specific needs of their employees is essential to controlling costs and improving quality health care. For this reason, we support the approach in H.R. 3080 of expanding access to coverage through small employer reforms.

Some proponents of small market reform believe employers should not be permitted to self-fund their health benefits. They believe that insured health plans would be the most efficient means to extend coverage to the working uninsured, most of whom are employed by small firms (many with less than 25 employees). SIIA disagrees with this proposal. Recent studies show that more than two-thirds of all employees covered by private health plans receive their benefits from self-insured health plans. Employers of all sizes who self-insure benefits for their employees and their families are doing so to reduce costs and gain more flexibility in designing and administering health benefit programs. In sum, there is no demonstrated need or justification for prohibiting employers, regardless of size, who choose to self-fund their health benefits from doing so.

MEWA Reform: We applaud the inclusion in H.R. 3080 of federal incentives and standards for strengthening multiple-employer purchasing groups. I refer to the much needed multiple-employer welfare arrangement (MEWA) reform provisions which would effectively regulate self-funded MEWAs, allowing employers to continue participation in these health care arrangements.

While large and medium sized companies have been the leaders in self-insurance, many companies with far fewer employees also self-insure their individual health plans. Thousands upon thousands of companies with fewer than 50 employees are self-funding and more are seriously considering this option. In addition, more than 5 million individuals and their dependents employed by small firms (less than 25 employees) participate in a variety of self-funded pooled health benefit arrangements which are sponsored by national trade associations and other business groups. A recent Department of Labor report noted that MEWAs lower administrative costs and help expand health coverage for smaller firms.

Any reformed health care system should utilize the experience of qualified associations and include industry and employer group pooling as a means of organizing the private sector consumer market. This provision recognizes that MEWAs are a viable option in providing health benefits for employers within such a pooled purchasing framework. Thousands of businesses will be able to continue providing affordable health coverage to employees and their families if the MEWA reform provision is adopted.

Other Reforms

Other reforms included in H.R. 3080 which merit support include:

1. **Malpractice** - SIIA supports effective malpractice reforms, including requiring binding arbitration between consumers and health care providers. We also support the imposition of sanctions against those who present fraudulent or frivolous claims.
2. **Administration Simplification** - SIIA supports standardized claim forms and procedures for administering claims and outcome analysis for both private and public health benefit plans. Cost shifting by federal and state governments and duplication of benefits should be eliminated.
3. **Fraud and Abuse** - SIIA supports criminal penalties for health care fraud and the imposition of sanctions for over-utilization of medical services.

Regulatory Framework

As for the health reform regulatory system, we believe that health reform and cost reductions can only be accomplished through a national framework that preempts state laws, including mandated benefits laws and taxes. The federal government must have exclusive authority over reform of the health care system in order to ensure a uniform environment for the efficient provision of health care coverage.

Nationally uniform rules establishing a health care market based on competitive forces is essential to the private sector's ability to cut costs and improve quality. In particular, uniform rules are critical to the ability of multi-state employers to efficiently administer health benefit plans. Allowing states to vary health rules governing small employers -- the largest percentage of the market -- creates as many problems as allowing states to regulate large multi-state employer plans. Unless there is federal uniformity, state rules governing the largest segment of the market are likely eventually to impact the rules governing large multi-state employers. For these reasons, we urge this Subcommittee to support a federally regulated system.

Conclusion

We believe that H.R. 3080 provides a viable framework for health care reform by addressing many weaknesses in the current health system while preserving and enhancing its strengths. The great majority of all Americans have health care coverage, most of whom are covered through their employers. The type of untested managed competition system proposed by the Administration and others is not a proven panacea for solving the nation's health care problems, and would only serve to disrupt the present system. Any health reform can be accomplished only through a national framework that preempts any and all state laws as necessary to assure uniformity and consistency in the rules that apply to health benefit plans. We believe that H.R. 3080 builds on the present system and will encourage more competition, as well as more choices for consumers and employers in selecting efficient, affordable health plans.

SIIA would be pleased to work with the Subcommittee to share information about how H.R. 3080 could be developed further to address your concerns and ours.

Respectfully Submitted,

SELF-INSURANCE INSTITUTE OF AMERICA, INC.

George J. Pantos
Washington Counsel

James A. Kinder
Executive Vice President

Mr. WAXMAN. Mr. Sullivan.

STATEMENT OF HENRY SULLIVAN

Mr. SULLIVAN. Thank you, Mr. Chairman.

The Food Marketing Institute appreciates this opportunity to share our views on health care reform, especially H.R. 3080, the Affordable Health Care Now Act of 1993.

The food distribution industry employs close to 4 million Americans. Nearly all—97 percent—of FMI's members offer health care insurance to their full-time and long-term employees. Our industry does employ many part-timers. The typical supermarket employs more than 50 part-timers. New larger stores employ well over 100 part-timers. Most of these are entry-level positions filled by younger individuals gaining job experience.

The cost of providing health care insurance to 50 part-timers in a typical store—those 50 part-timers—under any scenario exceeds \$100,000 per store. Clearly, this is a huge cost for an industry with a bottom line of 0.5 of 1 cent on sales. In 1993, the year ending in March, it was 0.49 of a cent of profit.

Our member companies, in cooperation with their associates, have developed a variety of successful, innovative approaches to control costs and improve access to health care services including managed care, wellness programs, utilization review, as well as cafeteria plans.

FMI believe that our health care system has serious problems that need to be addressed. For a number of years we have been actively seeking reforms designed to control costs and to expand access to care, building on the strengths of our current system. At the same time, we have opposed plans such as the current Health Security Act that would radically restructure our health care system and create new and more severe problems than currently exist.

H.R. 3080 adopts a series of important reforms strongly supported by FMI. These include creation of voluntary insurance purchasing groups; basic affordable benefits packages; insurance reforms, including preexisting conditions and portability; a 100 percent deduction for all employers, including the self-employed and individuals; preemption of State benefit mandates and anti-managed care laws; reform of medical malpractice laws; administrative and paper reform; and subsidies for the low income and near poor.

We believe that a consensus exists in the Nation and in the Congress for an enactment of these provisions. A number of other bills have been introduced that include variations on the common themes. Indeed, the administration's plan includes many of these ideas.

We strongly urge that these important reforms be enacted now so that the problems that do exist in our health care system can begin to be addressed. Moreover, we urge the Congress to reject any plan that calls for huge new government bureaucracies, adding new costs for small businesses and food retailers and their employees, thereby stifling the major source of job creation in our economy.

The provisions in H.R. 3080, on the other hand, will go a long way to address our health care needs without damaging our economy. FMI strongly supports these alternative approaches.

Thank you, Mr. Chairman and members of the subcommittee.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Sullivan follows:]

STATEMENT
OF THE
FOOD MARKETING INSTITUTE

THE FOOD MARKETING INSTITUTE (FMI) APPRECIATES THIS OPPORTUNITY TO SHARE OUR VIEWS ON HEALTH CARE REFORM, ESPECIALLY H.R. 3080, THE AFFORDABLE HEALTH CARE NOW ACT OF 1993.

FMI IS A NONPROFIT ASSOCIATION CONDUCTING PROGRAMS IN RESEARCH, EDUCATION, INDUSTRY RELATIONS AND PUBLIC AFFAIRS ON BEHALF OF ITS 1,500 MEMBERS — FOOD RETAILERS AND WHOLESALERS AND THEIR CUSTOMERS IN THE UNITED STATES AND AROUND THE WORLD. FMI'S DOMESTIC MEMBER COMPANIES OPERATE APPROXIMATELY 19,000 RETAIL FOOD STORES WITH A COMBINED ANNUAL SALES VOLUME OF \$190 BILLION — MORE THAN HALF OF ALL GROCERY STORE SALES IN THE UNITED STATES. FMI'S RETAIL MEMBERSHIP IS COMPOSED OF LARGE MULTI-STORE CHAINS, SMALL REGIONAL FIRMS AND INDEPENDENT SUPERMARKETS.

THE FOOD DISTRIBUTION INDUSTRY EMPLOYS CLOSE TO 4 MILLION AMERICANS. NEARLY ALL (97%) OF FMI'S MEMBERS OFFER HEALTH CARE INSURANCE TO THEIR FULL-TIME AND LONG-TERM EMPLOYEES. OUR INDUSTRY DOES EMPLOY MANY PART-TIMERS. THE TYPICAL SUPERMARKET EMPLOYS MORE THAN 50 PART-TIMERS. NEW, LARGER STORES EMPLOY WELL OVER 100 PART-TIMERS. MOST OF THESE ARE ENTRY-LEVEL POSITIONS, FILLED BY YOUNGER INDIVIDUALS GAINING JOB EXPERIENCE. THE COST OF PROVIDING HEALTH INSURANCE TO 50 PART-TIMERS IN A TYPICAL STORE, UNDER ANY SCENARIO, EXCEEDS \$100,000 PER STORE. CLEARLY, THIS IS A HUGE COST FOR AN INDUSTRY WITH A BOTTOM LINE OF ONE-HALF OF ONE CENT (.49 FOR THE FISCAL YEAR ENDING MARCH, 1993) OF PROFIT FOR EVERY DOLLAR OF SALES.

OUR MEMBER COMPANIES, IN COOPERATION WITH THEIR ASSOCIATES, HAVE DEVELOPED A VARIETY OF SUCCESSFUL, INNOVATIVE APPROACHES TO CONTROL COSTS AND IMPROVE ACCESS TO HEALTH CARE SERVICES. BUT INDIVIDUAL COMPANIES CAN ONLY DO SO MUCH.

THE FOOD MARKETING INSTITUTE BELIEVES THAT OUR HEALTH CARE SYSTEM HAS SERIOUS PROBLEMS THAT NEED TO BE ADDRESSED. FOR A NUMBER OF YEARS WE HAVE ACTIVELY SOUGHT REFORMS DESIGNED TO CONTROL COSTS AND EXPAND ACCESS TO CARE, BUILDING ON THE STRENGTHS OF OUR CURRENT SYSTEM. AT THE SAME TIME WE OPPOSE PLANS SUCH AS THE CURRENT HEALTH SECURITY ACT THAT WOULD RADICALLY RESTRUCTURE OUR HEALTH CARE SYSTEM AND CREATE NEW AND MORE SEVERE PROBLEMS THAN CURRENTLY EXIST.

THE AFFORDABLE HEALTH CARE NOW ACT OF 1993 ADOPTS A SERIES OF IMPORTANT REFORMS STRONGLY SUPPORTED BY FMI. THESE INCLUDE:

- CREATION OF VOLUNTARY INSURANCE PURCHASING GROUPS TO HELP SMALLER BUSINESSES AND UNINSURED INDIVIDUALS BUY INSURANCE AT AFFORDABLE RATES. EXISTING REGULATORY BARRIERS PREVENTING GROUPS OF EMPLOYERS FROM JOINING TOGETHER TO PURCHASE INSURANCE WOULD BE ELIMINATED.
- BASIC AFFORDABLE BENEFITS PACKAGES WOULD BE DEVELOPED AND INSURERS SELLING TO SMALLER BUSINESSES WOULD BE REQUIRED TO OFFER THESE PLANS.

- INSURANCE REFORMS WOULD MAKE HEALTH INSURANCE COVERAGE EASIER AND LESS EXPENSIVE TO BUY. EMPLOYERS AND EMPLOYEES WOULD BE GUARANTEED THAT THEIR COVERAGE CAN'T BE CANCELED, AND THAT THEY WON'T BE EXCLUDED BECAUSE OF PRE-EXISTING CONDITIONS. BY ASSURING CONTINUOUS AVAILABILITY OF COVERAGE, JOB-LOCK WOULD BE ENDED.
- ALL EMPLOYERS, INCLUDING THE SELF-EMPLOYED AND INDIVIDUALS WHO PURCHASE THEIR OWN COVERAGE, WOULD BE ALLOWED A 100 PERCENT DEDUCTION FOR HEALTH INSURANCE PREMIUMS. THIS WILL ENCOURAGE THE PURCHASE OF COVERAGE.
- COSTLY STATE BENEFIT MANDATES AND ANTI-MANAGED CARE LAWS WOULD BE PREEMPTED, REDUCING COSTS.
- MEDICAL MALPRACTICE LAWS WOULD BE REFORMED REDUCING EXCESS, COSTLY OVER-TREATMENT.
- ADMINISTRATIVE AND PAPERWORK REFORM PROVIDING FOR UNIFORM CLAIMS FORMS AND ELECTRONIC BILLING WOULD HELP REDUCE ADMINISTRATIVE COSTS.
- SUBSIDIES WOULD BE PROVIDED FOR LOW INCOME, NEAR POOR INDIVIDUALS WHO CAN'T AFFORD INSURANCE TO BRING RECIPIENTS INTO PRIVATE INSURANCE PROGRAMS.

WE BELIEVE THAT A CONSENSUS EXISTS, IN THE NATION AND IN THE CONGRESS, FOR ENACTMENT OF THESE PROVISIONS. A NUMBER OF OTHER BILLS HAVE BEEN INTRODUCED THAT INCLUDE VARIATIONS ON THESE COMMON THEMES. INDEED, THE ADMINISTRATION'S PLAN INCLUDES MANY OF THESE IDEAS.

WE STRONGLY URGE THAT THESE IMPORTANT REFORMS BE ENACTED NOW SO THAT THE PROBLEMS THAT DO EXIST IN OUR HEALTH CARE SYSTEM CAN BEGIN TO BE ADDRESSED.

MOREOVER, WE URGE THE CONGRESS TO REJECT ANY PLAN THAT CALLS FOR HUGE NEW GOVERNMENT BUREAUCRACIES, ADDING NEW COSTS FOR SMALL BUSINESSES AND FOOD RETAILERS AND THEIR EMPLOYEES, THEREBY STIFLING THE MAJOR SOURCE OF JOB CREATION IN OUR ECONOMY.

THE PROVISIONS IN H.R. 3080, ON THE OTHER HAND, WILL GO A LONG WAY TO ADDRESS OUR HEALTH CARE NEEDS, WITHOUT DAMAGING OUR ECONOMY. FMI STRONGLY SUPPORTS THESE ALTERNATIVE APPROACHES.

Mr. WAXMAN. I want to thank all three of you for your testimony. I think you have given us very important information for the record. I appreciate it.

Our last panel this afternoon brings together four organizations that will testify in opposition to H.R. 3080:

Dr. Henry Simmons, the executive director of the National Leadership Coalition for Health Care Reform. It is a coalition representing over 100 employers, unions, consumers and provider organizations. Kathy Hurwit is the legislative director of Citizen Action. Dr. Denman Scott is vice president of the American College of Physicians. And Louise Novotny is a research economist with the Communications Workers of America.

We are pleased to welcome you to our hearing today. Without objection, your full statements will be made a part of the record. I would like to ask each of you to limit your testimony to no more than 5 minutes.

Dr. Simmons, why don't we start with you?

STATEMENTS OF HENRY E. SIMMONS, PRESIDENT, NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM, ACCOMPANIED BY MARK A. GOLDBERG, DEPUTY DIRECTOR; CATHY HURWIT, LEGISLATIVE DIRECTOR, CITIZEN ACTION; H. DENMAN SCOTT, SENIOR VICE PRESIDENT FOR HEALTH AND PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS; AND LOUISE NOVOTNY, RESEARCH ECONOMIST, COMMUNICATIONS WORKERS OF AMERICA

Mr. SIMMONS. Thank you, Mr. Chairman. We also appreciate the opportunity to speak today about health system reform and H.R. 3080, and I appear on behalf of the National Leadership Coalition for Health Care Reform with our deputy director Mark Goldberg.

Our Coalition is the largest and most diverse alliance on health care issues. We consist of nearly 100 organizations—major businesses in all sorts of industries and many of the Nation's largest union, consumer and provider groups which together include as employees or individual members about 100 million Americans.

Our Coalition is absolutely nonpartisan. Our honorary cochairmen are former Presidents Carter and Ford. Our cochairmen are former Iowa Governor Bob Ray, a Republican, and Paul Rogers, a Democrat, who served as a member of your subcommittee for 20 years and chairman for 8.

Health care reform, in our judgment, is an issue on which bipartisanship is essential, and former Presidents Carter and Ford recently noted that in a Washington Post op-ed on behalf of the Coalition, and we are committed to working with members of both parties to achieve effective reform.

We commend Congressman Michel and those of you who have collaborated with him on what has clearly been a lot of hard work. You have made an important contribution to the national debate, and H.R. 3080 sets out in detail many components that our Coalition supports and firmly believes ought to be incorporated in whatever reform legislation you ultimately adopt such as insurance reforms, administrative cost savings, malpractice reform and improved access to rural health services.

Our Coalition also believes, however, that the final reform legislation must include much more aggressive measures to bring health care coverage to all Americans, to constrain health care spending and to improve the quality of care. We know, as all of you surely, do that the legislation that finally passes is likely to include ideas and language from many of the bills now before Congress. We hope that you will carefully consider these suggestions:

First, we urge you to report out a bill that is designed to achieve universal coverage. According to a recent report by EBRI, the number of Americans without health insurance increased 2.3 million between 1991 and 1992, the largest increase in the last decade, and these men, women and children live daily in physical and financial peril. This is a national tragedy, and we have to do better.

Now, the Coalition is so committed to seeking reform that extends coverage to all Americans for a number of reasons: First of all, it is the only humane thing to do. It is the right thing to do. But, equally important, we know that, without universal coverage, we will never be able to put a stop to the national shell game of cost shifting or control our costs or have true competition.

Second, we urge you to report out a bill that aggressively constrains increases in health care spending.

And here, Mr. Chairman, I would like to include for the record the latest U.S. industrial outlook where the Department of Commerce has estimated that U.S. health care spending last year increased over \$100 billion, the largest 1-year increase in history. And Commerce further projects that it will raise at an average rate of 13.5 percent a year over the next 5 years, doubling our health care costs.

We can't go on this way. We need insurance reforms, yes, but we also need much more. And our recommendation is that legislation include expenditure targets and rate setting for the fee-for-service segment of the system—to keep spending increases in bounds while organized delivery systems, which would not be subject to rate schedules, are encouraged to grow, and, over time, we can increase the competitiveness of health care. In the meanwhile, we ought to make sure that costs don't continue to spiral out of any control.

And, third, the Coalition urges that you report out a bill that includes comprehensive measures to improve the quality of care that Americans receive. We know, although we talk about it less often than we should, that there are very serious problems in the quality of American health care. And as a physician it pains me to say that, and it doesn't mean that some of it isn't the best in the world but far too much falls well short of that ideal.

Mr. Chairman, I would like to submit for the record a more detailed description of our recommendations as described in the *New England Journal of Medicine* essay by the Coalition in Volume 327.

To conclude, you all know that health care reform is an extraordinarily complex undertaking. It is also extraordinarily important. You have an opportunity to make life better for Americans now and for generations to come, and we urge you that now is the time to be bold, to dream big dreams and to help make them come true.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Simmons, and we will receive the additional information you wish to submit for the record.

[The prepared statement of Paul E. Rogers follows:]

STATEMENT OF THE HONORABLE PAUL G. ROGERS

Mr. Chairman, I am Paul G. Rogers, co-chairman of the National Leadership Coalition for Health Care Reform and a partner in the law firm of Hogan & Hartson.

I very much appreciate the opportunity to speak with the members of this subcommittee about health care reform -- and, specifically, about H.R. 3080. I appear before you today on behalf of the National Leadership Coalition. With me is Mark A. Goldberg, deputy director of the Coalition.

The National Leadership Coalition is the nation's largest and most diverse alliance on health care issues. As the list appended to my written testimony indicates, the Coalition consists of nearly 100 organizations -- major businesses in all sorts of industries, unions, consumer groups, and associations of health care providers. Taken together, these organizations include -- as employees or individual members -- about 100 million Americans.

The Coalition is absolutely non-partisan. Our honorary co-chairmen are former Presidents Jimmy Carter and Gerald R. Ford. Our co-chairmen are former Iowa Governor Robert D. Ray and myself; Bob is a Republican, and I am a Democrat. We are committed to working with members of both parties to achieve effective reform.

Mr. Chairman, as you know, I am a former chairman of this

subcommittee. I know that this subcommittee has been able to develop or refine an enormous amount of important legislation over the years -- and I know that the subcommittee has been able to be so productive in large part because Democrats and Republicans on the subcommittee have worked together so often and so effectively.

Health care reform, in my judgment, is an issue on which bi-partisanship is essential. As former Presidents Carter and Ford recently wrote in The Washington Post, in an op-ed that is also appended to my testimony,

[T]he problems of our health care system do add up to a crisis -- and we need to attend to it with the urgency, and the willingness to put aside partisanship, that a real crisis warrants.

I commend Congressman Michel, my old friend and valued colleague, and those of you who have collaborated with him on behalf of H.R. 3080. With what has clearly been a lot of hard work, you have made an important contribution to the national debate about reform. H.R. 3080 includes, and sets out meticulously and in detail, many components that the National Leadership Coalition firmly believes ought to be incorporated in whatever reform legislation that Congress ultimately adopts: insurance reforms, administrative cost savings, medical malpractice liability reform, and improved access to rural health services. These steps would help to make health insurance more accessible and affordable, and health care itself more readily available, to more Americans.

The National Leadership Coalition also believes, however, that the final reform legislation needs to include more aggressive and ambitious measures to bring health care coverage to all Americans, to constrain health care spending, and to improve the quality of care that Americans receive. We know, as all of you surely do, that the debate about reform is fluid -- and that the legislation that finally passes is likely to include ideas and language from many of the bills now before the Congress. We hope that you will carefully consider these suggestions:

First, the National Leadership Coalition urges members of this subcommittee to report out a bill that is designed to achieve universal coverage. According to a recent report by the Employee Benefit Research Institute, the number of Americans without health insurance jumped between 1991 and 1992 from 36.6 million to 38.9 million -- an increase in just one year of 2.3 million. That, according to the Institute, is the largest increase in the last decade. These men, women, and children live every day in physical and financial peril. This is a national tragedy. We must do better.

Why is the Coalition so committed to seeking reform that extends coverage to all Americans? Because America is a humane society, and we believe that no American should die or suffer because he or she cannot afford health insurance. Because we do not want the health or children to depend on whether they had the good fortune to be born into families with adequate health coverage. Because we know that without universal coverage, we

will never be able to put a stop to the national shell-game of cost-shifting. Because our national prosperity and security depend on the health of our people. Because it is right.

Second, the Coalition urges that you report out a bill that more aggressively, and more comprehensively, constrains increases in health care spending. The Department of Commerce recently estimated -- in a study that received little attention because it was released between Christmas and New Year's -- that U.S. health care spending in 1993 totaled \$942.5 billion. That's an increase from 1992 to 1993 of \$102.3 billion -- the largest one-year increase in history. And Commerce projects that health care spending will rise at an average rate of 13.5 percent per year over the next five years.

We can't go on this way. We need insurance reforms, yes, but we also need more. Our recommendation is that legislation include expenditure targets and rate-setting for the fee-for-service segment of the health care system -- to keep spending increases in bounds while organized delivery systems, which would not be subject to rate schedules, are encouraged to grow. Over time, we can increase the competitiveness of health care delivery systems; in the meanwhile, we ought to make sure that costs don't continue to spiral out of any control.

Third, the Coalition urges that you report out a bill that includes comprehensive measures to improve the quality of care that Americans receive. We know, although we talk about it less

often than we should, that the quality of American health care is not all that it should be -- not because some of it isn't the best in the world, but because too much of it falls well short of that ideal. We need to do more outcomes research, we need to codify the best available information into practice guidelines, and we need to do more to make outcomes measures available to patients and payers.

Health care reform is an extraordinarily complex undertaking. It is also extraordinarily important. This Congress has an opportunity to make life better for Americans, now and for generations to come. Now is the time to be bold, to dream big dreams and make them come true.

Jimmy Carter and Gerald R. Ford This One Can't Wait

American politicians and policy makers tend to overuse the word "crisis." Not every problem, not even every serious one, deserves that label. But the problems of our health care system do add up to a crisis—and we need to attend to it with the urgency, and the willingness to put aside partisanship, that a real crisis warrants.

We have an extraordinary political opportunity, and we must move quickly to come together around a strategy for reforming the health care system. Never before has there been the degree of consensus that now exists—about the importance of systematic change and the general contours of what ought to be done—in the business and labor communities, among the providers of health care and, perhaps most striking, on the part of the broader public. This is not to say that everybody agrees on details—or that agreement on details will be easy to achieve. But we have never had a better chance to do so than now.

We need to move expeditiously, not only to pass reform but to implement it. The crisis of the health care system is intensifying. Every year, millions of Americans who have health

"What matters [in health care reform] is not who scores political points but who helps to secure the health of Americans."

coverage lose it. Children are born to mothers who were unable to get adequate prenatal care—and these children in turn often go without basic preventive care, which they would receive in virtually any other industrialized nation in the world.

Every year, the costs of health care increase dramatically. In 1993, the United States is expected to spend more than \$930 billion on health care—\$400 billion more than we spent just five years ago. This escalation of cost is draining off funds that could otherwise be used to expand businesses and create jobs, pursue other social goals (such as improvement of the educational system), improve the living standards of Americans, reduce the deficit and, for that matter, provide health coverage to those who are without it. And every year, far too many Americans suffer needlessly from care that is inappropriate or poorly delivered. We need to work hard, and soon, to improve the quality and the consistency of care.

Whatever strategy for health care reform we adopt needs to incorporate and reflect the urgency of our difficulties. We cannot afford the luxury of patience. Let us move quickly to decide what to do—and then let us do it as quickly as we prudently can.

We are heartened both by President Clinton's recent call for a bipartisan effort on health care reform and by the reaction to it, from governors and congressional leaders in both parties. Ours is a nation that has flourished in part because of our willingness and ability to make necessary distinctions between those matters that were appropriately the subject of ideological and partisan debate and those that, because of their central importance, called for an extra measure of collaboration and resolve.

In the late 1940s, for example, Sen. Arthur Vandenberg, a Republican during the administration of a Democratic president, made an eloquent case for bipartisanship in foreign policy. The issues America needed to address, he said, were so crucial to our future and the world's future that politics should end at the water's edge.

It is time now to adapt the Vandenberg principle to health care reform. Politics should end at the hospital door.

We hope that the president, the governors and members of Congress in both parties will work together, not against each other, on health care reform. What matters is not who gets credit but that we get effective and workable reform. What matters is not who scores political points but who helps to secure the health of Americans, now and in the future.

We are optimistic about the prospects—in large part because we have worked together for the past several years as honorary cochairmen of a huge alliance of businesses, unions, consumer groups and associations of health care providers that back tough, realistic reform. That alliance, the

National Leadership Coalition for Health Care Reform, has operated on a purely nonpartisan basis from its inception.

Its members—more than 100 varied groups—have managed to reach consensus on a reform strategy that would control costs through expenditure targets and rate-setting, guarantee coverage to every American within three years of passage and launch a major effort to improve the quality of care. We know from this experience that the support for comprehensive reform is broad and deep—and that if health care is approached as a genuine crisis rather than as just another issue, the force of common concerns will be able to overwhelm the inertia of parochialism.

Politics as usual may be good enough for usual matters. But the health care crisis is in a very special, highest-level category. It requires the exercise, by many people at once, of the most enlightened form of the political art: statesmanship.

Former presidents Carter and Ford are the honorary cochairmen of the National Leadership Coalition for Health Care Reform.

Mr. WAXMAN. Ms. Hurwit.

STATEMENT OF CATHY L. HURWIT

Ms. HURWIT. Thank you very much. I, too, would like to thank the subcommittee for the opportunity to testify here today.

Mr. Chairman, I particularly would like to thank you for your leadership over the past years in trying to win comprehensive health care for all Americans.

Citizen Action, in looking at health care reform, has basically judged the different proposals against six major principles. It is our belief that H.R. 3080, unfortunately, fails to meet any of those six principles. What I would like to do in my testimony today is briefly outline why we think that the bill fails to meet those principles.

The first principle is one of universal coverage. Without a guarantee of health care for every American and without the requirement that employers contribute to the health care coverage for their workers and their families, we do not believe that every American will be able to get health care.

Looking at H.R. 3080, there are many Americans who are left out even of the requirement that coverage be offered to them, let alone—let alone there is no guarantee that even if the insurance is offered to them they will be able to afford it. Gaps will contain. Portability will not be assured. People who change jobs, if they do not have the salary or if their employers do not offer to contribute, may be without coverage.

Second, we do not believe that H.R. 3080 meets the fundamental principle of providing comprehensive benefits. As you are aware, there is no uniform benefit package even outlined in the bill. Small businesses would be required to provide an insurance package based on actuarial equivalency of current small business policies, but even their insurance companies are able to change the benefits as they will.

Moreover, we are very concerned with the requirement that all benefits, even if they are in the package, be essential and medically appropriate, particularly concerned because it appears to us that insurance companies, not physicians or providers and their patients, are the determiners of whether those benefits are essential and medically appropriate.

Let me also just briefly say here that, in terms of the preexisting condition exclusions, we are concerned that those condition exclusions are limited although not eliminated and there only in the group market, not for individuals who may have health care problems.

The third principle of affordability to families and businesses we do not believe is met either. Financing premium payments are not based on the ability to pay. We believe that low wage and moderate workers and their families will not be able to afford unlimited premiums.

Interestingly enough, H.R. 3080 does include caps, premium caps, but only for small businesses, and then they allow those premiums to increase by 15 percent a year plus. We do not think that is affordable for small businesses or small-business employees.

The next principle is one of cost savings efficiencies as opposed to setting financial obstacles to people getting care. We do not be-

lieve that H.R. 3080 meets that principle either. There are no controls, no fee schedules, no caps, as Dr. Simmons has pointed out.

The next principle, one of choice, again, we do not think is met by this bill. First of all, millions of Americans will remain uninsured and will only be able to go to emergency rooms, will have no choice of providers.

Second, by maintaining an employment link to coverage, many employers will be able to choose even if they are only choosing the offer of coverage for their workers.

And, finally, H.R. 3080 includes provisions which we believe will prohibit people from being able to get out-of-network care if they choose to get into managed-care plans.

Finally, and this is a very—extremely important principle for us, the principle of public accountability and consumer participation. We view H.R. 3080 as increasing the role of the insurance industry in controlling the health care system. There is no consumer role. There is no appeals process for people who are unhappy with denials of treatment and claims. There is no public decision-making on the capital investments that you heard mentioned by an earlier panel. There are no anti-discrimination provisions to prevent unfair marketing.

In short, for the reasons that I have just mentioned, we believe that H.R. 3080 is not the correct solution to our Nation's health care crisis. We would encourage instead this subcommittee to look at H.R. 1200, the American Health Security Act, which we believe does meet those principles.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Ms. Hurwit.

[The prepared statement of Ms. Hurwit follows:]

Citizen Action

1120 19th Street, N.W., Suite #630
Washington, D.C. 20036
(202) 775-1580
(202) 296-4054 (FAX)

H.R. 3080, THE AFFORDABLE HEALTH CARE NOW ACT OF 1993

STATEMENT OF CATHY L. HURWIT LEGISLATIVE DIRECTOR, CITIZEN ACTION

BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

FEBRUARY 1, 1994

On behalf of Citizen Action, I would like to thank the Chairman and members of the Subcommittee for this opportunity to provide our comments on H.R. 3080, the Affordable Health Care Now Act of 1993. We greatly appreciate the role that this Subcommittee has played in addressing the health care needs of Americans and look forward to working with you in passing comprehensive health care reform this year.

Citizen Action is a federation of state organizations with three million members in 33 states. Our membership is diverse both geographically and economically, including workers and business owners, the insured and the uninsured, rural and urban dwellers. Over the past years, Citizen Action organizations have been active in health care reform efforts at both the state and federal levels.

In my testimony today, I would like to begin by outlining the components that Citizen Action believes are essential to implementation of meaningful reform. The second part of my testimony will address whether H.R. 3080, the Affordable Health Care Now Act of 1993, incorporates those components.

First, however, I feel compelled to address the question of whether the United States faces a health care crisis or a health care problem. While on the surface this may appear to be a matter of semantics, it is being posed in manner that seeks to differentiate those who believe that structural health care reform is required to protect all Americans from those who believe that only incremental reform is needed to address the problems facing the uninsured.

Everyone here today can name individuals, families and businesses who are facing health care crises -- unnecessary illnesses or deaths, Medicaid-lock or job-lock, or bankruptcies. The statistics show that these are not just isolated instances.

On any given day in 1992, 38.9 million Americans had no insurance, 20 percent of them children. The number of uninsured rose by 4.2 million from 1989 to 1992. More than half of that increase -- 2.3 million -- occurred between 1991 and 1992. Despite the efforts that this Subcommittee has made to cover additional pregnant women and children under Medicaid, the number of uninsured children increased in 1992, largely because of a drop in the number of dependents covered through their parents' job-based insurance.

The uninsured population is not static. The Employer Benefits Research Institute estimates that 53 million Americans are uninsured for a month or more during a year. Other estimates are that 2 million Americans lose their health insurance every month, some to regain it after a short gap, others continue for longer periods without coverage.

Even those with insurance may be facing health care crises. Up to 50 million insured Americans are inadequately insured. Five million women of child-bearing age lack maternity coverage. Twenty million Americans are so underinsured that a major illness or injury would result in financial disaster. And, as the Alzheimer's Association has recently reported, over 200 million Americans have no protection against the cost of long-term care.

The inadequacy of insurance coverage is likely to increase given the incidence of employers shifting costs to employees. A recent U.S. Chamber of Commerce survey of more than 1100 firms employing more than 2.6 million workers found that the cost of health coverage to employers rose by one percent between 1991 and 1992, nine percent to employees. As the value of benefits rose faster than wages, the ability of workers to maintain current benefits for their families is eroding.

Most Americans would classify a situation of this magnitude as a crisis, whether it affected them personally or not. Others would, to paraphrase the old saw about the difference between a recession and a depression, define it as a problem if it affected someone else's family but a crisis if it affected their own.

Citizen Action falls in the category of those who believe our health care system is in crisis. For those who disagree, the question they must answer is whether what they see as a problem can be prevented from becoming a crisis.

The reality is that the trends which have created personal health care crises for tens of millions of Americans are continuing or accelerating. Uninsurance rates are increasing. The U.S. Department of Commerce projects medical expenditure increases of 13.5% a year for the next five years. Businesses are continuing to reduce benefits, cost-shift to employees, or eliminate coverage. More than three out of every five employers that offer retiree health coverage have changed their benefit plans or are planning to cut back or terminate benefits within the next year.

But even for those unconvinced that the current situation and the trendlines add up to a crisis, the question is whether their proposed incremental reforms would make any significant improvements or accomplish any of the major goals of comprehensive health care reform.

The Goals of Health Care Reform: Over the coming weeks, this Subcommittee will debate many critical issues and approaches. While our members have many specific concerns which we hope to have the opportunity to share with members of the Subcommittee, Citizen Action believes that there are six fundamental goals which must be achieved for reform to be meaningful and effective. These are the basic standards against which we will measure health care proposals:

Universal coverage: The United States must join the rest of the industrialized world in guaranteeing universal and portable health care coverage. That guarantee must be provided in as timely a fashion as possible, with a firm date included within the legislation. Every American must be guaranteed access to health care regardless of their income, age, location, employment or health status. No one should be confronted with the loss of coverage or with financial hardship to obtain care.

Comprehensive benefits: Health insurance coverage must include all necessary medical care, including the full range of preventive, acute and chronic care services. Pre-existing condition limitations and exclusions must be prohibited. Physicians and their patients, not insurance companies, should determine what services are medically necessary or appropriate.

Affordability: Individuals and families should be required to contribute through a broad-based system based on their ability to pay, not on health status or utilization. All businesses should be required to pay their fair share as well. Cost-sharing requirements that present financial obstacles to care must be eliminated.

Cost savings: Universal, broad coverage and fair financing cannot be guaranteed if health care spending continues to increase at rates two to three times the rate of inflation, wage growth, and family income. Cost controls must eliminate administrative and other waste in the system by the use of overall budgets, annual negotiations for uniform fee schedules, and the presence of a powerful entity to bargain and act on behalf of individual and business consumers.

Choice: The opportunity for all individuals and families to seek the highest quality care for their families depends on their ability to select their own source of care. Even for those who select a managed care option, provisions must be included to allow out-of-network care when appropriate. Requirements of additional payments for fee-for-service or higher-quality plans and out-of-network treatment will eliminate or restrict the choices available to lower-income and moderate-income families.

Consumer Participation and Public Accountability: Consumers should be provided with a decisionmaking role in a reformed health care system. Moving from a complex, fragmented and top-heavy health care model to one which stresses universality, fairness and

more effective use of resources. To ensure that decisions are made in the public interest, individuals and employers must be able to influence policies and implementation.

After a review of all existing proposals, Citizen Action has endorsed H.R. 1200, the American Health Security Act, as the best approach to meeting those six fundamental goals. According to the Congressional Budget Office, H.R. 1200 would reduce annual medical spending by \$114 billion by the year 2003, while providing universal and comprehensive coverage, including long-term care. H.R. 1200 promotes quality through outcomes research and reporting, practice guidelines, the requirement that states act to address disparities in health status, and guaranteed choice of providers with no financial restrictions.

Citizen Action will continue to look at legislative proposals to determine whether and how well they meet the standard set by H.R. 1200.

The Affordable Health Care Now Act of 1993, H.R. 3080: While Citizen Action has many specific concerns about the provisions of H.R. 3080, I would like to focus on why we believe that this legislation fails to meet the six major components which we believe are absolutely essential to meaningful reform. In a number of areas, not only do we believe that this legislation will fail to move towards a solution, we believe it will allow the current crisis to worsen.

Universal coverage: H.R. 3080 does not even attempt to provide a guarantee of universal coverage. There is no requirement that individuals or businesses purchase insurance and no proven method to finance coverage for those who cannot afford it. Instead, H.R. 3080 would encourage individuals to purchase private insurance by making group rates available to some and through changes in the tax code.

Publicly-funded tax deductions are offered to encourage those previously uninsured to purchase coverage, but these are unlikely to be effective. First, eligibility is limited to persons who are not now eligible for employer-subsidized health plans and were not eligible for employer-subsidized coverage over the previous three years. The level of employer subsidization is not specified. There are numerous examples of persons who would be ineligible for this deduction: employees unable to afford the individual share of premium, employees unable to afford coverage who become able to do so because of a change in jobs or increase in income. Second, the amount of the deduction -- beginning at 25% of the premium -- may be insufficient. Finally, the front end costs of coverage are likely to remain unaffordable.

Because a major factor in the decline in private insurance coverage has been attributed to a decrease in employer contributions (whether in terms of elimination or a reduction in employer contributions), the policy that "an employer is not required...to make any contribution to the cost of coverage..." (Section 1001(a)(3)) will do nothing to reverse the growth in the uninsured due to a decline in job-based coverage. Instead, as the cost of coverage continues to increase, even more employers may act by eliminating contributions, making premiums even more unaffordable to workers and their families and adding to the ranks of the uninsured.

H.R. 3080 also does nothing to provide a guarantee of continuous coverage. Employment changes could result in loss of coverage if there is no voluntary employer contribution or the employee cannot afford to pay their required share of the premium. If even an employee could afford to pay the required premium, gaps in coverage could occur in light of the allowed 60-day waiting period for even the offer of coverage or if the employee is unable to afford coverage during the initial open enrollment period.

Instead of providing a guarantee of coverage through mandatory individual or employer contributions (or both), H.R. 3080 relies on a totally voluntary system of insurance reform that, based on state experience, is unlikely to succeed. Interestingly, many of the insurance reforms (such as guaranteed issuance or renewal) in the legislation are limited to firms with 2-50 employees, despite the fact there is a significant number of uninsured workers in larger firms (one in three uninsured persons work for businesses with over 100 employees and 7.2 million uninsured persons are in families headed by employees in firms with 1,000 or more employees) and that the problem of obtaining coverage is particularly acute for individuals.

Even the requirement that employers offer coverage, which employees may or may not be able to afford, is not universal. New businesses do not have to offer coverage for two years. Businesses with one or two eligible employees (excluding relatives at the employer's discretion) are exempt. Part-time employees (less than 30 hours a week on a monthly basis) are excluded. Individuals are not mentioned.

There are a few provisions in H.R. 3080 that may make insurance available to the uninsured, such as access to group rates or guaranteed issuance requirements. States are given the option of expanding coverage under Medicaid -- including allowing a Medicaid buy-in option for persons up to 200% of poverty -- but would have to use existing Medicaid funds (including funds for disproportionate share hospitals) to do so. Even if states use this option, the result of H.R. 3080's Medicaid provisions could be a reduction in the quality and level of benefits available to existing beneficiaries.

The reality is that without mandatory employer contributions, there can be no guarantee of universal coverage and little progress toward expanding access to the currently uninsured. In fact, the Congressional Budget Office estimated that last year's version of the legislation would expand private coverage to only 200,000 persons.

Comprehensive benefits: H.R. 3080 fails to meet the goal of ensuring access to comprehensive benefits in a number of ways. Not only would those few people who may receive new coverage under the legislation fail to obtain necessary services, but many Americans who are currently insured could see the scope of their coverage narrow.

First, H.R. 3080 fails to establish a uniform benefit package, either in the legislation or through a commission. Instead, employers must offer (although, again, not contribute to the cost of) standard coverage based on the actuarial value of policies typically offered in the small employer market. Insurance plans would be able to offer benefits, including medical, surgical,

hospital and preventive services, as long as the value is within 5 percentage points of the target. This leaves the actual benefits up to the discretion of each insurer and also seems to preclude the offering of plans which exceed the actuarial target by five percentage points (at least under the definition of standard coverage). The reliance on typical small employer coverage as a standard fails to acknowledge that such coverage may provide an inadequate level of services. Moreover, since this is the standard coverage which is to be offered by all businesses -- small, medium and large -- it is likely to be an actuarial value far below the benefits now being provided by larger firms.

Second, H.R. 3080 in defining the benefits used to set the actuarial target and the benefits for MedAccess plans mentions only medical, surgical, hospital and preventive services but then goes on to state that "no specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations." Therefore, it is not even certain that services within those categories will be provided let alone important benefits missing from the list altogether, such as prescription drugs, home care, durable medical equipment, hospice, and long-term care.

Third, H.R. 3080 preempts the application of state or local laws which require the coverage of specific benefits, services, or services of types of providers in the case of group health plans. This means that services such as substance abuse, breast reconstruction, mammography screening and prosthetic devices as well as services provided by nurses, nurse practitioners, and social workers might no longer be covered.

Fourth, H.R. 3080 sets an "essential and medically necessary" standard which is more restrictive than other alternatives which use language such as "medically necessary or appropriate." By allowing insurance companies to make this determination, H.R. 3080 virtually guarantees an acceleration of insurance company intrusion into the physician-patient relationship. Moreover, H.R. 3080 preempts state laws which would provide consumer protections against arbitrary and unfair arbitrary review practices, such as liability for delays in performing review, requiring 24-hour availability or setting utilization review standards.

Fifth, H.R. 3080 fails to eliminate the use of pre-existing condition clauses, which could affect up to 81 million Americans. While the bill does set limits on the use of such those clauses, the limits apply only for group health plans. Individuals with pre-existing conditions are not afforded protections and may be charged significantly higher premiums or denied coverage altogether. Even in group health plans, a six-month limitation or exclusion is allowed except for newborns covered under the plan and pregnancy. Persons not continually insured, and there is no guarantee of continual coverage or the affordability of premiums, could face repeated 6-month gaps in coverage for pre-existing conditions.

Sixth, H.R. 3080 does nothing to provide additional needed benefits such as prescription drugs or home and community based care services to Medicare beneficiaries. While Medicare spending is reduced, none of those savings goes to extend protections to beneficiaries.

Affordability: While H.R. 3080 seeks to provide some persons with access to group premium rates, there is no guarantee that premiums will be affordable to either individuals, families or businesses who voluntarily agree to contribute to the cost of coverage.

With its reliance on premium-based financing, H.R. 3080 does recognize the need for some limits on premium variations and premium increases. Unfortunately, the bill not only limits the application of these provisions to small businesses with less than 51 employees, it also sets the premium variations and caps at levels too high to afford much protection. Insurers would be able to vary premium among classes of small businesses by 20% (each insurance company establishes its own classes of business) and then to charge small businesses within the same class 150% of the base premium rate for that class (eventually falling to 135%). Thus, the premium rates charged to similarly situated small businesses and their employees could differ dramatically.

Just as H.R. 3080 does not guarantee affordable premiums, premium increases could continue at high levels. Small employers, the only group "protected" by limits on annual premium increases, could see premiums increase by 15 percent plus the premium rate increase for a newly-covered small employer within the same class of business rate.

Apart from premiums, individuals and families would be required to pay "substantial" cost-sharing (not defined in the bill) under the standard plan and high deductibles under the catastrophic plans. Even if the standard plan were affordable, "substantial" cost-sharing could restrict access to necessary preventive and acute care services. Unless a medical savings account were affordable and coupled with a catastrophic plan, even higher cost-sharing requirements -- deductibles of at least \$1,800 person or \$3,600 per family -- would make access even more difficult.

Finally, H.R. 3080 does not establish annual out-of-pocket spending limits, prohibit balance billing, or ban the use of lifetime limits.

Cost savings: The Congressional Budget Office has estimated that last year's version of H.R. 3080 would increase national health expenditures only slightly. More important, it would have no mitigating effect on future price increases. It has already been pointed out that the only price limits -- limits on premium increases for small businesses -- would allow annual double-digit inflation. (In fact, the 15 percent plus increases allowed are higher than the Congressional Budget Office's estimate of 13.5% annual medical inflation.)

There are no guaranteed mechanisms to restrain expenditure growth in H.R. 3080, (such as budgets or uniform payment schedules). Yet, H.R. 3080 would increase taxpayer funding of health care through a range of provisions such as increased tax deductions for self-employed persons and previously uninsured persons who buy private insurance, full tax deductibility for medical savings accounts, and increased tax deductions for long-term care insurance. If public funding of health care expenditures is to be increased, it is logical that some taxpayers would question whether those expenditures will be cost-effective and future spending will be controlled.

The same argument is true of the option under H.R. 3080 for states to enroll low-income persons into private health insurance plans under a Medical Health Allowance Program. Given the range of studies concluding that public programs spend less on administrative costs than private insurers, the move towards privatization in this area appears to be ill-conceived from a cost-effectiveness perspective.

Choice: Because so many Americans would remain uninsured under H.R. 3080, their choice of provider may be limited to a hospital emergency room. But there are additional ways in which the bill restricts or fails to expand consumer choice.

First, those employees offered plans through their employers could face an extremely limited number of options. Small employers who have not contributed to coverage during the previous year must offer a MedAccess standard, catastrophic and Medisave plan, although only one plan in each category needs to be offered and the language suggests that even these limited choice requirements do not apply if coverage under an HMO is offered. Other employers can limit choice to only one plan.

Second, insurance companies will be able to offer plans with limited choice of providers. Because group plans would no longer be subject to state laws requiring access to different types of providers, such as nurse practitioners, insurance companies would be able to restrict both the numbers and types of practitioners available.

Third, H.R. 3080 not only fails to provide any guarantee that enrollees in managed care plans can go out-of-network for cause, it preempts state laws that place limits on the amount of additional payments which enrollees could be forced to pay if they want out-of-network services.

Fourth, H.R. 3080 not only encourages the use of managed care under Medicaid and Medicare, it preempts federal law limiting Medicare/Medicaid beneficiary enrollment to 75 percent in order to protect quality.

Finally, because H.R. 3080 fails to provide uniform payments, reimbursement differentials will continue to exist between Medicaid and private insurers, making it difficult for Medicaid beneficiaries to find providers willing to accept them as patients.

Consumer Participation and Public Accountability: Increasingly, consumers and providers are expressing concern about the power of the insurance industry in controlling health care policy and decisions regarding the delivery of care. Unfortunately, H.R. 3080 not only fails to give consumers or providers a guaranteed mechanism to influence these issues, it strengthens the position of large insurance and managed care corporations.

While health insurance companies are exempt from federal regulation, a recent report by the U.S. General Accounting Office emphasizes the fact that consumers can expect little protection from state regulatory agencies. The average state insurance department spends only

one-quarter of its operating funds on health insurance regulation. Fourteen states had no actuary either on staff or under contracts. The majority of states do not even review premium rates before they go into effect. It is small wonder that many consumers do not even go through the motions of lodging complaints about their insurance company.

Single-payer proposals such as H.R. 1200 seek to redress this imbalance by eliminating the insurance companies as middle-men in fee-for-service plans and requiring consumer participation in managed care plans. In proposals in which the insurance industry is allowed to remain intact, powerful bodies, comprised of consumers (both individual and business) and sometimes providers are created to protect the public interest and offset the market power of large corporate entities. Under H.R. 3080, however, neither option is chosen. Instead, consumers (especially individuals who are not eligible for the group coverage and therefore not eligible for even minimal protections such as guaranteed issuance or renewal) still have no voice.

Even where H.R. 3080 seeks to provide consumers with information, there is little assurance that the information will be meaningful or available. The provisions requiring state comparative value information require only limited information relating to the average prices of common health services and health insurance plans. Information on price variations within a state or, more importantly, specific market area is not required. Only after six years is the state required to provide information on quality and outcomes data, even though measures such as waiting times, immunization levels, and claims denials should be readily available. States are responsible for the plans and there is no requirement that plans make such information available during open enrollment periods or provide the information in a form which will be easily understandable.

While H.R. 3080 on the one hand does little to improve the ability of consumers to influence health care decisionmaking or make informed decisions (assuming they have the funds with which to purchase coverage), it does prevent states from acting to protect their residents in the areas of managed care policies, choice of providers, and utilization review.

Conclusion: Citizen Action believes that H.R. 3080 would do little to ease the health care crisis facing millions of Americans or slow the expenditure growth and cost-shifting trends which will exacerbate that crisis. Citizen Action does not believe that the legislation's reliance on voluntary actions to guarantee coverage and control costs, on managed care, and on an increased role for private insurance companies represents an effective solution.

Instead, we urge this Subcommittee to craft legislation which will meet the six fundamental goals of universality, comprehensiveness, affordability, cost effectiveness, choice, and public accountability. Again, we look forward to working with you in that effort.

Mr. WAXMAN. Dr. Scott.

STATEMENT OF H. DENMAN SCOTT

Mr. SCOTT. Thank you very much, Mr. Chairman, for the opportunity to be here and speak on behalf of the American College of Physicians.

The College recognizes that the health care system is enormous and gives splendid care to millions. However, the ACP does believe that the system suffers in crisis now, mainly a crisis in access first and foremost. However, rising costs and aspects of quality are also major concerns.

The College is committed to fundamental reform. Incremental change is no longer acceptable. We must deal simultaneously with costs, access and quality. In this regard, we are pleased to be a part of Dr. Simmons Coalition and working with that group.

As far as H.R. 3080 is concerned, we do applaud one aspect of it in particular and that is its approach to medical liability. However, we do not believe that the voluntary approach in this bill will achieve universal access.

In this country when people get sick sooner or later—and often very late for many—they go to the hospital or doctor. Everyone expects health care. Everyone, therefore, should contribute dollars towards their health care.

The College supports a mandate on employers and individuals not working for someone else. Everyone deserves insurance. Everyone must contribute to it. We very much recognize, however, the need to subsidize people who are poor and certain small businesses. H.R. 3080, as some of my fellow panelists have pointed out, in no way deals substantively with cost control.

My final point: It does not also deal with the major imbalance between general primary care and specialty physicians, and it is redressing this imbalance which, long term, is an indispensable ingredient to dealing with the costs of health care.

That is all I have to say. Our comments are in our testimony. We appreciate the chance to be with you.

Mr. WAXMAN. Thank you very much, Dr. Scott.

[The prepared statement of Dr. Scott follows:]

STATEMENT
of the
AMERICAN COLLEGE OF PHYSICIANS
Before the
House Energy and Commerce Committee
Subcommittee on Health and the Environment
February 1, 1994

The American College of Physicians (ACP) is pleased to have this opportunity to present our views on pending health care reform legislation. The College is the nation's largest medical specialty society, representing more than 80,000 physicians practicing internal medicine and its subspecialties. I am H. Denman Scott, MD, FACP, MPH, ACP's Senior Vice President for Health and Public Policy.

The College is committed to fundamental reform of our nation's health care system. We have examined the concurrent problems of inadequate insurance and millions of Americans being without any form of health insurance coverage, spiraling increases in health care costs, and the growth of an administrative and bureaucratic system that is burdensome for patients, families and physicians. During the past six years, we have held hundreds of meetings on the topic of improving access to health care for all our citizens. These meetings have involved thousands of physician and staff hours by numerous committees of the ACP, our Board of Regents, our Board of Governors (member-elected leaders representing physicians in every state, the District of Columbia, Puerto Rico, as well as chapters in Canada and several other countries), and at regional membership meetings of ACP chapters across the country.

Let there be no misunderstanding. There is a crisis concerning our health care system. Incremental changes alone will not solve the complex problems involved. Nothing less than comprehensive, system-wide, health care reform is required to achieve universal access to health care for all Americans.

In May 1990, we published our first position paper on this topic (**American College of Physicians**. Access to health care. *Annals of Internal Medicine*. 1990;112:641-61). In this paper, we summarized some of the major problems with the present system, or lack thereof, and set forth our criteria for a better system. Subsequently, we have used these criteria to develop our own proposal (**American College of Physicians**. Universal insurance for American health care. *Annals of Internal Medicine*. 1992;117:511-19) and to evaluate other proposals for health care reform.

I would like to emphasize that no single proposal to date has completely satisfied all of our criteria for a better system. The Administration's Health Security Act appears to meet many of them, but it is weak on malpractice insurance reform, and it creates new layers of bureaucracy and regulation. We also have concerns that it may be undermined by allowing too much flexibility among the states, and that it may not assure that physicians have sufficient input concerning quality assurance activities and management of the new system.

However, today I would like to focus my remarks on the Michel bill, reflecting the proposals of the House Republican Leader's Task Force, and the Cooper-Grandy Managed Competition Act.

We evaluated each proposal according to how well they would help achieve universal access to high quality health care services, control health care costs, and provide comprehensive coverage. We also considered their ability to accomplish malpractice insurance reform, assure that sufficient numbers and types of health care professionals are available, minimize bureaucracy and administrative requirements, and maintain opportunities for innovation and technological improvement.

Universal Health Insurance Coverage

We found that neither the Michel nor the Cooper-Grandy bills would achieve universal health insurance coverage. The Michel bill would require all employers without existing health benefit plans to offer at least one plan that meets an actuarially defined standard of coverage. Multiple employer purchasing arrangements, state-sponsored accessible health benefit systems, federal tax reforms and removal of certain IRS regulatory barriers, and small insurance market reforms should help to make group health insurance more affordable to small employers and their employees. However, employers would not be required to share any of the burden for paying premiums, and many individuals and their families would remain without coverage. The Michel bill also provides that individuals could establish medical savings accounts. These "Medisave Accounts" would be similar to individual retirement accounts (IRAs), and could be linked to catastrophic health insurance policies. Such accounts provide a weak substitute for health insurance and can be totally inadequate in meeting the costs of major illnesses.

As Congressman Cooper has indicated, his bipartisan plan would improve access to health insurance, but would not guarantee universal coverage. His managed competition plan would extend coverage to only about 60% of the uninsured. Large employers would be required to offer employees and their families enrollment in a managed care plan, but would not be required to contribute anything toward the cost of premiums. Small employers would not have to provide coverage, but would have to deduct premiums from employee wages for those workers who enroll in an Accountable Health Plan (AHP).

Cost Control

We are particularly concerned that the Michel bill has no specific provisions to effectively help control rising health care costs. Cooper-Grandy relies almost entirely on managed competition, providing tax incentives for employers to choose the lowest-price managed care plan that meets

minimum standards. However, limiting the tax deductibility of employer premiums to those of the lowest-cost managed care plans, could further restrict, rather than expand health insurance coverage.

Comprehensive Benefits

The Michel bill would provide that all employers, including small employers, must offer their employees at least a standard plan that covers essential and medically necessary medical, surgical, hospital, and preventive services. The employer is under no obligation to pay for this coverage, but the coverage must be offered. Target actuarial values would be developed by the private sector for standard and catastrophic plans, and insurers would have flexibility in developing benefit packages as long as they meet target actuarial values set for each plan.

The Cooper-Grandy bill would establish a Health Care Standards Commission that would recommend a federally-defined uniform set of effective benefits that must be offered. Congress would approve or reject a recommended package of benefits on an up-or-down vote. Benefits would have to be medically appropriate and treatment would have to be in accord with practice guidelines set by an Agency for Clinical Evaluations. Additional benefits would be available, but would not be tax deductible for employers or individuals.

While the College is in agreement with the intent of both of these proposals -- to assure that all plans offer a basic, uniform set of comprehensive and medically effective benefits -- it is difficult to make further assessments without specific details on what would be in the uniform benefits package. We are concerned that the limits on tax deductibility under Cooper-Grandy would place a substantial impediment on employers from offering benefits that are any more generous than the federally defined uniform effective benefits package.

Other Provisions

There are many commendable provisions in both the Michel and Cooper-Grandy bills that should be mentioned. Both contain needed insurance market reforms to minimize or eliminate restrictive provisions concerning pre-existing conditions, enable small insurers to obtain more affordable group insurance, and to better assure that employees do not lose health insurance coverage when they change jobs. Both seek to minimize administrative inefficiencies by facilitating adoption of uniform claims forms and by encouraging electronic claims processing. Both also address the need for coverage of preventive health care services.

In addition, both offer meaningful malpractice reforms, including alternative dispute resolution (ADR) systems to resolve liability claims, caps on non-economic damage awards, and limits on contingency fees. We urge the substitution of these provisions for those in the Health Security Act.

The Cooper-Grandy bill also contains provisions for addressing the nation's health workforce needs. It includes financing provisions to assure that appropriate graduate medical education programs are adequately funded. The Michel bill contains no provisions concerning the physician workforce.

Conclusion

In summary, although there are many commendable provisions in both of these bills, they fail to adequately address the major criteria of assuring universal health insurance coverage for all Americans and establishing effective means to control health care costs. They both provide a basis for a comprehensive benefits package, but fail to provide the details of what would be covered. The American College of Physicians is supportive of many of the provisions concerning medical liability reform, insurance market reforms, improvements in administrative efficiency, development of a national health professions workforce policy, and financing of graduate medical education. We look forward to working with you and your colleagues as you proceed in further the developing legislation. Thank you.

Mr. WAXMAN. Ms. Novotny.

STATEMENT OF LOUISE NOVOTNY

Ms. NOVOTNY. Good afternoon. Thank you very much.

As you may know, CWA represents 600,000 workers in the telecommunications industry and the broadcast industry, in the public sector and in the health care industry, and it is on behalf of those members that I am here today. I appreciate the opportunity.

For all the members of our union and in every one of those sectors, health care has been a flash point in bargaining over the past decade. In fact, our goal in bargaining has been to assure our members access to necessary and quality medical care through comprehensive benefit plans that allow them to preserve their standard of living.

In recent years, though, our ability to meet this goal has been challenged by another seemingly futile goal: Trying to keep the costs of our health plans within a range that is acceptable to our employers.

In our most recent round of bargaining with the Bell Telephone operating companies in 1992, employers proposed further cuts in our health benefits in spite of the cost-effective managed-care networks we had negotiated in 1989. We oppose the cuts because they would restrict our members' access to care but would do nothing to control the real causes of health cost increases.

Our experience led us to conclude that our twin goals of assuring access and controlling costs cannot succeed at the bargaining table, as large as our bargaining units are, and, as you may know, AT&T and the Bell operating companies are quite large. Our bargaining units alone range in size from 40,000 to 100,000 members. We and our bargaining partners simply do not have the market clout necessary to keep health costs affordable over the long run.

We began to look for a solution to our health care problems in a different arena aside from the traditional bargaining arena, and we developed five key criteria to assess health care reform proposals and to determine whether our members would benefit from the provisions. Our criteria are very much like those that Ms. Hurwit outlined.

We want universal coverage.

There must be guaranteed, comprehensive benefits covering a broad range of services.

Any proposal must provide affordable coverage—that is, affordable for individuals and families as well as the country as a whole.

We want a system that assures quality care by protecting the doctor-patient relationship and the choice of provider.

And, last, we want a new health care hierarchy that puts patient care first over profit motives and cost-cutting considerations.

There are only two bills that we see before Congress that meet these goals. One is the American Health Security Act, H.R. 1200, and the other is the Health Security Act, H.R. 3600. CWA has endorsed both these bills.

The other bills before Congress fall short of our goals of affordable, comprehensive health coverage for everyone.

H.R. 3080 is one of the bills that does not measure up. First of all, it is not universal. Although the plan would require all employ-

ers to offer coverage to their employees, the employers are not required to make any contributions to the coverage. In addition, since the bill focuses primarily on opening up insurance options for small business employees, CWA members who, for the most part, are employed by large employers will not be assisted in our perennial struggle to preserve and improve the benefits we have negotiated.

Moreover, part-time and temporary workers would not be eligible for the option of coverage under H.R. 3080. In the telecommunications industry, the growing use of temporary and part-time workers, many of whom work 20 hours a week, by both our competitors and our own employers has become a serious threat to our members' job security.

In the broadcast industry, daily hires have become a common practice of employment for broadcast technicians. These workers get no health benefits today because employers are not required to cover them, and they would receive no protections under H.R. 3080.

Another recent trend in the telecommunications industry is the wave of layoffs and downsizing as firms reorganize. Under H.R. 3080, there is no guaranteed coverage during periods of unemployment unless the laid-off workers become eligible for Medicaid. Guarantees of availability exist under H.R. 3080 only if the individual is employed. Promises of coverage are made only to those who can afford to purchase the insurance.

Employers sometime facilitate the downsizing and avoid direct layoffs by enhancing pension rules so that more senior employees can retire early. At the same time, employers are cutting back on retiree health benefits.

Today, there is no legal requirement that employers bargain with us over benefits for retired members, and we anticipate that, unless comprehensive health care reform is enacted this year, protection of retiree health benefits will be our biggest battle when we bargain with AT&T and the Bell operating companies in 1995. H.R. 3080 offers no guarantees of health coverage for these individuals and their families, and it makes our responsibility to bargain for protections for them no easier.

I know. I have some more comments to make.

Mr. WAXMAN. Well, that whole statement is going to be in the record.

Ms. NOVOTNY. Thank you very much for the opportunity to speak.

Mr. WAXMAN. Thank you.

[Testimony resumes on p. 774.]

[The prepared statement of Ms. Novotny follows:]

H.R. 3080, The Affordable Health Care Now Act of 1993

Statement of Louise Novotny

Research Economist, Communications Workers of America

Before the House Subcommittee on Health and Environment

February 1, 1994

Good afternoon. My name is Louise Novotny. I am a Research Economist with the Communications Workers of America. CWA represents 600,000 workers in the telecommunications industry, the publishing and broadcast industries, the public sector, and the health care industry. For the past five years my primary responsibilities at CWA have been to develop guidelines for negotiating health benefits in our major collective bargaining agreements and to develop a union policy on national health care reform. I am pleased to be here today to share with you our views on health care policy. CWA looks forward to working with this committee to develop a lasting solution to the nation's health care crisis as experienced by our members.

CWA members believe there is a health care crisis. They believe it because over the past decade in virtually every round of collective bargaining in each of our bargaining units, health care has been a major flash point in the negotiations. Mushrooming health costs have pressured our employers to seek cuts in our health benefits, pushing cost increases onto workers. Our wage increases have given way as health care consumes more and more of our total compensation packages. The cost of these bargaining battles is often high. Our members have had to strike to protect their health benefits. The irony is that in some cases, our members lost their health coverage because they exercised their federally-protected right to strike.

The majority of CWA members work for AT&T and the seven regional Bell Telephone companies. We have been negotiating benefits with those companies for about three decades. Over that time the members of CWA have built what is considered to be a leading edge health plan. We built it a piece at a time, paying for the package out of our total negotiated compensation. Our goal has been to assure our

members access to necessary and quality medical care through comprehensive benefits plans that allow them to preserve their standard of living.

In recent years our ability to meet that goal has been challenged by another, seemingly futile goal -- trying to keep the cost of our plans within a range acceptable to our employers. At the bargaining table we have had some success with cost containment initiatives that redirect the way our members receive care. We negotiated HMO coverage, second surgical opinions, incentives for outpatient surgeries, and programs to reduce length of hospital stays. Data from our companies indicate that these programs were partially effective. Utilization under our health plans has been declining. Hospital admissions have been reduced, length of stay has shortened, and services have been shifted to more cost efficient outpatient settings. Even our most recent experiment with point of service managed health care networks has proven capable of holding cost increases to a more manageable level over the short run.

But these modest successes have not realized sufficient savings to appease our employers beyond the next contract. In our most recent round of bargaining with the Bell Telephone Operating Companies in 1992, employers proposed further cuts in our health benefits in spite of the cost-effective managed care networks we negotiated in 1989. The proposed cuts included caps on the amounts they will contribute to retiree health coverage, limits on mental health benefits, carving out coverage for dependents, and increased cost-sharing by employees.

We rejected the proposals because they would restrict our members' access to care, but would do nothing to control the real causes of health cost increases. The elements driving the rise in the cost of our health plans are not within our control on a micro, company-by-company scale. Those elements include:

- an aging population with increased health care needs;
- the dissemination of new and expensive high-tech equipment often without regard to the needs of the community but instead as a provider strategy to increase market share;

- health care price inflation which has accelerated at about twice the rate of overall inflation over recent years;
- and cost shifting as providers increase charges for services covered under our plans in order to pay for the cost of caring for the uninsured and underinsured.

Our experience led us to conclude that our twin goals of assuring access and controlling costs cannot succeed at the bargaining table in the long run. As large as our bargaining units are (the AT&T and Bell company units range in size from 40,000 to 100,000 employees), we and our bargaining partners simply do not have the market clout necessary to keep health costs affordable over the long run. Therefore, the ability of both the union and the employer to guarantee access to health care for our members and their families in the future is limited.

CWA began to look for a solution to our health care problems outside the traditional bargaining arena. We developed five key criteria to assess health care reform proposals and to determine whether our members would benefit from the provisions.

First, we want universal health coverage. Everyone must be covered by health benefits no matter where we work or whether we work. CWA members believe health care is a right, and have learned that the employment-based system no longer will assure our access to needed care over our lifetimes.

Second, the guaranteed benefits must be comprehensive, covering a broad range of services including the standard hospital and physician services as well as preventive care, long term care, and rehabilitative services.

Third, any proposal must provide affordable coverage. That is, the program must be affordable for individuals and families, for employers, and for the country as a whole. In CWA's view, an affordable health care system would include financing linked to ability to pay and effective, centralized cost controls that assure affordability over the long run.

Fourth, we want a system that assures quality care by protecting the doctor-patient relationship and choice of provider. In addition, we look for proposals that will assist in the development of practice guidelines, quality standards and protections for front-line health care workers in order to improve the practice of medicine and quality of care.

And fifth, we want a new health care hierarchy that puts patient care first over profit motives and cost cutting considerations. This would require a new system of public accountability that puts consumers and front-line health care workers in decision-making roles to influence the policies and programs of the reformed health care system.

There are only two bills before Congress that meet these goals -- the American Health Security Act, H.R. 1200 and the Health Security Act, H.R. 3600. CWA has endorsed both these bills.

Other bills before Congress fall short of our goals of affordable, comprehensive health coverage for everyone. Today, we grateful to have the opportunity to share our views on H.R. 3080, the Affordable Health Care Now Act. It is one of the bills that do not measure up well according to our key criteria for reform.

First of all, it is not universal. Although the plan would require all employers to offer coverage to their employees, the employers are not required to make any contributions to the coverage. (Sec. 1001(a)). Making coverage "available" falls far short of CWA's goal of guaranteed coverage. In addition, since the bill focuses primarily on opening up insurance options for small business employees, our members will not be assisted in our perennial struggle to preserve and improve the benefits we have negotiated.

Moreover, there is a significant group of workers who would not even be offered the options outlined in the bill. Eligible employees are defined as those who "normally perform on a monthly basis at least 30 hours of service per week for that employer." (Sec. 1023(a)(2)). In other words, part-time and temporary workers would not be eligible for the option of coverage under H.R. 3080.

We are seeking ways to secure more benefits for these workers. We are looking for solutions that will assure them equitable compensation and needed health coverage while at the same time eliminating financial disincentives for employers to hire full-time workers.

We can envision a number of equitable solutions. One is to require all businesses to pay a percentage of payroll or income to help finance a universal health care system. Another is to require employer contributions on behalf of all workers who provide services during a week, defining full-time work as 30 hours a week and prorating contributions for all hours less than 30.

Another recent trend in the telecommunications industry is the wave of layoffs and downsizing as firms reorganize. We have negotiated benefits to protect laid off workers for a period of time, but we cannot protect these members during extended periods of lay off. While H.R. 3080 would protect these individuals from waiting periods for pre-existing conditions should they find a new job, there is no guaranteed coverage during periods of unemployment unless the laid-off workers become eligible for Medicaid. Guarantees of availability exist under H.R. 3080 only if the individual is employed. Promises of coverage are made only to those who can afford to purchase the insurance.

Downsizings in the telecommunications industry and others is also characterized by early retirement sweeteners. That is, employers facilitate the downsizing and avoid direct lay-offs by liberalizing rules for retirement so that more senior employees can retire with enhanced pension benefits. But these workers are faced with another dilemma. Employers are trying to get out from under promises of retiree health benefits in order to lighten the weight of the retiree health liability they must now post on their books. Employers are cutting back on retiree health benefits.

Today, CWA members who retire early (before age 65) are protected only by the benefits we negotiate. There is no legal requirement that employers bargain with us over benefits for retired members. We anticipate that unless comprehensive health care reform is enacted this year, protection of retiree health benefits will be our

biggest battle when we bargain with AT&T and the Bell Operating companies in 1995. H.R. 3080 offers no guarantees of health coverage for these individuals and their families, and it makes our responsibility to bargain for protections for them no easier.

On our second goal for health care reform, comprehensive benefits, H.R. 3080 falls short as well. Though the bill mandates that insurers offer three types of plans, benefits are not explicitly defined -- only general descriptions are provided. For example, the standard plan is one which provides "standard coverage ... with substantial cost sharing." (Sec. 1102(a)(1)(A)(i). The Medisave plan couples medical savings accounts with catastrophic coverage that includes a deductible of at least \$1,800 per person and \$3,600 per family. (Sec. 2202).

The high degree of cost sharing included in the H.R. 3080 would rule out the label of comprehensive benefits and could prevent people from receiving needed care if they cannot afford the high out-of-pocket costs. Linking the high catastrophic deductible with the medical savings accounts restricts that benefit program to those with high levels of disposable income that can be set aside for a rainy day. Many low-wage and middle-class workers will be unable to take advantage of this new insurance market.

Rather than defining specific covered benefits, H.R. 3080 instructs that the Secretary of Health and Human Services will request the National Association of Insurance Commissioners (NAIC) to develop a set of rules for determining the actuarial value of the coverage included in typical small employer health plans and to establish a target actuarial value for standard coverage. (Sec. 1102(b)(1) and (c)2)). A plan will be certified if its value is within five percentage points of the target. (Sec. 1102(c)(1). Without a prescribed package of benefits, the bill cannot meet our standard for comprehensiveness. As important, our goal of increased public accountability is undermined when authority for benefits standards is vested in an entity that is not directly responsible to the public, nor its proceedings open to public scrutiny.

H.R. 3080 also falls short of our third goal, affordability. The failure to require employer contributions to the health care system is a key flaw.

CWA believes all employers should contribute to the health care system because all businesses, large and small, benefit from a healthy and productive workforce. Other benefits flow when all employers pay into a system that covers everyone. Employers who now provide insurance coverage for their workers will very likely realize a savings over current expenditures as health costs are spread more equitably across the economy. Spreading the costs will require employers who do not now provide benefits to pay their fair share, leveling the competitive playing field for those employers who have been responsibly contributing to their workers health coverage. Employers who realize a savings will be able to re-channel those monies back into the company in the form of higher wages for workers, reinvestment in plant and capital, and more jobs.

Though the bill includes some premium limits, they do not offer much protection or assure that plan costs remain truly affordable. Annual premium increases are limited only for plans offered by small employers - those with 51 or fewer employees. Insurers could charge these small employers up to 15% more than the premium rate increase charged to a newly covered small employer in the same class of business. (Sec. 1105). In addition, premium increases for any class of business of an insurer may be set as much as 20% higher than the premium increase for another class of business. (Sec. 1104(a)(1)(A)).

Premium rates for small employers with similar demographic and other characteristics and within the same class of business of an insurer can be up to 50% more than the lowest premium rates within the class. After three years, that variation allowance is reduced to 35%. (Sec. 1104(a)(2)).

These protections against premium increases for employers and individuals are, at best, minimal. They apply only to small employers and are set at such high levels that many small employers will find no relief. A 15% to 20% annual increase in premiums is considered by most of us to be a serious cost spiral.

Since it offers no protections against exorbitant out-of-pocket costs, H.R. 3080 also fails to achieve affordability for individuals and families. The "substantial cost sharing" of the standard plan and the high

deductibles of the catastrophic plan make the benefits unattainable for low-wage and middle-class families. There are no limits on the amounts plans may require for deductibles, co-payments and coinsurance, so consumers remain vulnerable.

There are no controls in H.R. 3080 that would protect insurance purchasers, both employers and individuals and families, from unregulated price increases. Health care providers may charge patients for amounts not covered by insurance and there are no bans on lifetime limits.

In summary, the members of CWA would find no true relief from the health care crisis as they experience it. There are no guarantees of coverage for everyone regardless of their employment situation; there are no comprehensive benefits; and there are no cost controls to keep health care affordable for our members and our employers. To address these issues, larger, more comprehensive reforms must be contemplated by Congress.

As I mentioned earlier, CWA has endorsed and supports two bills now before Congress. We endorsed H.R. 1200 because it guarantees everyone comprehensive health coverage from cradle to grave. Under the American Health Security Act, people have access to all medically necessary services no matter where they work or whether they work. Laid off workers, workers on strike, retired workers and their families are covered. There is no change in coverage because of a disruption in employment circumstances. The unemployed, low-income families and senior citizens are guaranteed the same scope and level of services as everyone else. In other words, under the American Health Security Act, health care is a right, not merely a fringe benefit.

The American Health Security Act guarantees a full and comprehensive range of services, including standard hospital and physician services, preventive care, mental health and substance abuse benefits, and long term care.

H.R. 1200 is affordable both to individuals and to businesses. It links health care contributions to ability to pay through payroll and income taxes. Our telephone operators will pay less toward health care than the

highest paid managers. That's fair. That kind of equity is not achievable under a system based on premiums and out-of-pocket costs.

In addition, our employers will find substantial relief from ever-rising health costs under the American Health Security Act. Cost-shifting from the uninsured to our plans is the current system of financing care for the uninsured. The American Health Security Act spreads the cost of health care across the whole spectrum of society, and as a result, the cost of care per person is greatly reduced for employers who now provide coverage.

The national health care budget included in H.R. 1200 will have a direct link to the national ability to pay since it is conditioned on growth in gross national product. This realistic restraint on the portion of our national resources devoted to health care will encourage health care providers to plan thoughtfully for capital expansions and new acquisitions based on community need, not according to competition for market share.

For the Communications Workers of America, the American Health Security Act achieves all our goals for universal, comprehensive coverage and cost-effective and affordable health care services. It is, we believe, the plan that will best serve the needs of the entire country.

The other bill in Congress that meets our criteria is the Health Security Act, H.R. 3600. The Health Security Act is a major step forward in the effort to address the national health care crisis. For those of us who have been fighting to protect health benefits at the bargaining table and who have been pressing the national grassroots demand for guaranteed health coverage, this bill's call for a universal, comprehensive benefits package for every American offers new hope. The plan is not perfect, but it comes close to achieving all of our goals for national health care.

- It achieves coverage for everyone by 1998, including expanded access to under-served areas and subsidies for low-income families and early retirees.

- It requires all employers to contribute to the cost of health care.
- It establishes a substantial benefits package while at the same time protecting existing additional benefits through tax-preferred treatment.
- It imposes some cost controls such as an enforceable national health care budget, prohibition on balance billing by providers, and limits on premium increases.
- Finally, it allows states to implement single payer systems as a model for achieving universal, comprehensive coverage within their jurisdictions.

These elements of the Health Security Act are significant achievements. They are far superior in scope and effectiveness to most health care proposals now before Congress. If enacted, these aspects of the bill would lift the U.S. from that ignoble distinction of being one of only two industrialized countries that do not guarantee their citizens the right to health care. These are good reasons to support H.R. 3600.

Thank you very much for this opportunity to share our views. The Communications Workers of America look forward to working with the members of this Committee to craft a national health plan that will resolve, once and for all, the national health care crisis.

Mr. WAXMAN. This has been an excellent panel. I appreciate your testimony.

I was particularly struck by Dr. Simmons' comments about the millions of people who are uninsured now and those who are being added to the rolls, which prompts me to ask this question of each of you, if you would—or whoever wants to respond—for your perspectives as employers, unions, providers and consumers.

Assume that we enact Mr. Michel's bill and that we implement it on January 1, 1997, as it currently provides. What do you think will happen to health care costs between now and 1997, between 1997 and 2000? And will the number of uninsured Americans increase or decrease between now—and implementation—between now and after 1997?

Mr. SIMMONS. We can start that.

I guess we would have no reason to doubt the figures that were presented to you by your own independent Congressional Budget Office in their July report which basically said, in analyzing a variety of bills including Mr. Michel's bill, that we would almost double our costs in that 7-year period of time, and the bill would have virtually no impact on the number of uninsured. And given that we have not done our detailed analysis but given the reforms that are proposed there, we, I think, would have to agree with that.

But Mark Goldberg has done sort of a back-of-the-envelope calculation and can share a few other things with you.

Mr. GOLDBERG. As Dr. Simmons said, we haven't done any econometric analysis for the outyears in your question. But if we look at years between now and 1997 and simply extrapolate from what we have got going on now in the system, according to the Employee Benefit Research Institute costs are going to go up, as Dr. Simmons said, about 13.5 percent for each of those years between now and 1997, which would mean that in 1997, the first year of implementation, we would be running an annual health care spending bill in excess of \$1.5 trillion.

Again, just doing a simple straight line extrapolation in the last 3 years for which we have numbers—that is, 1989 through 1992—the increase in the number of uninsured was 4.2 million. If roughly that rate of increase continued between now and the date of implementation, at the time of implementation we would have about 46 million uninsured Americans.

Mr. WAXMAN. Thank you.

Ms. Hurwit.

Ms. HURWIT. I have very little to add to that.

I think that the Congressional Budget Office projected that last year's version of the bill would actually add about 200,000 people to the rolls of the insured.

One of the concerns we have is that many people who now are insured may find themselves in the rolls of the uninsured. And one of the things that we have seen with the figure of 2.3 million Americans added to the rolls of the uninsured between 1991 and 1992 is many of them were workers whose employers dropped coverage, including many children. And we are seeing a growth in the number of uninsured children, despite the efforts to get more children onto Medicaid.

I would also just like to add that one of the concerns we have is—when you talk about uninsurance versus insurance—one of the real issues is what do we mean by insurance. At the same time that we see the trends of cost increases and the number of uninsured Americans, increasingly we also see the numbers of inadequately insured Americans increasing. We are very concerned that if trends continue—and we don't believe that H.R. 3080 will mitigate any of those trends—you will see people with less coverage, higher deductibles, higher co-payments, less choice, which will prohibit them from getting the care that they need.

Mr. WAXMAN. Thank you.

Dr. Scott.

Mr. SCOTT. I don't have any precise numbers on this business, but it is clear, I think, as we think about the problem, that until we get everybody under the tent we are going to spend tremendous energy keeping people out selectively and throwing other people out. Once we get everybody in the system, then we can start dealing with how to take care of them, how to get the maximum efficiency or much better efficiency than we have today and stop this huge expenditure of energy of doing what we are doing.

If we have that particular approach enacted, I don't think there will be incentives on the part of businesses or individuals to buy insurance when this is passed any more than there is for them to buy today. For some people, sure, they will go out there because they may be able to get something a little more affordable, but a lot of insurance people won't deal with it and a lot of businesses that can get the work force they want today without providing these benefits. And why would they want to change that policy if they can get the people they want to work for them?

So we have to move from what is a voluntary system to one which says everybody has got to be in and everybody has got to contribute except for the poor and those people who are in small business who do deserve some subsidy for a period of years.

Mr. WAXMAN. Ms. Novotny.

Ms. NOVOTNY. I will let the National Leadership Coalition—or I will stand by their numbers for a change.

But I just want to emphasize other points that people made and that seems to me to be the fact that these issues, the universal comprehensive cost controls, are inextricably linked. And if we are to cover everyone in the country—and I believe that is a serious goal of the majority of the U.S. population—then we are going to have to find some way to put the costs on so that we can keep it affordable over the long term and assure that benefits that we are guaranteeing to everybody are comprehensive.

Mr. WAXMAN. Thank you.

Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

I just want to mention to Dr. Simmons, your group visited my office with a contingent of about 12 or 13 folks, I think. Even Ms. Novotny's group was included in that as part of your Coalition. And I tell you, it was a very interesting conversation for about an hour and a half.

One of the things we found out was that your group was less than homogeneous, that you did have a broad range of views. And

there are so many divergent interests out there that it was quite an interesting argument among the members of your group.

But we do want to hold down costs. I guess there are a lot of different ways to approach this issue and many individuals have differing ideas. Hopefully, we can come together. Nobody is going to do this on a partisan basis. It has to be done on a bipartisan basis. Certainly, we hope that we can find the gems in all these policies and put together something that is going to serve this country.

So I appreciate the work you are doing and enjoyed talking to your group.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert.

Again, my thanks to this panel. You have been very helpful.

That concludes our testimony for today. We stand adjourned.

[Whereupon, at 3:09 p.m., the hearing was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted for the record:]

STATEMENT OF AMERICAN FEDERATION
OF GOVERNMENT EMPLOYEES

Mr. Chairman and members of the Committee: My name is John Sturdivant and I am the National President of the American Federation of Government Employees, AFL-CIO. On behalf of the more than 700,000 federal and District of Columbia employees our union represents, I thank you for the opportunity to testify. AFGE has been active for decades in the effort to reform our nation's health care system to one which resembles Canada's single payor format. It is therefore a pleasure to come before you today to engage in discussion over how to improve an already excellent blueprint for guaranteeing every American high-quality and affordable health insurance.

AFGE would like to congratulate President Clinton for keeping his promise to make national health care reform a top priority of his administration. The question of the day is no longer whether we need reform, but rather what is the best approach to reform. The President deserves credit not only for this, but also for keeping the principles of universal coverage and stringent cost containment at the heart of his proposals.

AFGE has been highly critical of the Federal Employees Health Benefits Program (FEHBP). Despite the fact that the approach to providing access embodied in President Clinton's plan appears to be modeled loosely on the FEHBP, we believe that it is structurally superior to FEHBP in many ways. In particular, it avoids risk segmentation by specifying a minimum standard benefit package, it avoids cost-shifting by providing universal coverage, and perhaps most important, it

provides genuine cost containment through global budgeting and coordinated allocation of health care technology.

The most critical failing of FEHBP from the perspective of employees has been inadequate employer financing. In 1989, the Congressional Research Service (CRS) conducted a comprehensive analysis of FEHBP and found that on average, the federal government spent \$1,100 less annually per employee on health insurance coverage than the typical large private sector employer. Despite the fact that some large corporations have increased out-of-pocket costs for their employees in recent years, that gap has increased slightly in the last four years. The most glaring and shameful result of the federal government's inadequate contribution to health insurance benefits for its employees is that according to the OPM's Central Personnel Data File (CPDP), 18.6 percent of federal employees who are eligible to participate in FEHBP do not. Almost half of these federal employees do not have health insurance coverage from another source.

To put it plainly: In 1990, 160,000 full-time, year-around, permanent federal employees had no health insurance, and when surveyed by OPM as to why they did not participate in FEHBP, they replied that they could not afford it. In testimony last week, OPM Director Jim King indicated that the number of full-time federal employees without any health insurance coverage had grown to 300,000.

According to President Clinton's own numbers, 30 million of the 37 million Americans who have no health insurance are employed. The sad fact is that 7 percent of the federal government's own career workforce has no health insurance because they lack the means to pay for it. This fact represents the failure of both the FEHBP as well as the nation's health care delivery system, of which FEHBP is just a small part. So it is in this context that we question the President's goal to leave federal employees "no worse off" as a result of reform. The health insurance benefits provided to federal employees must be improved under reform, not only for those who cannot afford coverage currently, but also for those who need more comprehensive and more affordable coverage than they currently receive.

Once the principle is accepted that elimination of FEHBP in favor of participation in regional health alliances established as part of the Health Security Act should leave federal employees better off, the difficult task of specifying the formula for improving their benefit begins. The question becomes how to take a group of 9 million active federal employees, annuitants, and their dependents, who are currently enrolled in more than 300 different plans with various premiums and benefits, and put them into a new system with at least 153 new plans (at 3 per state plus the District of Columbia) and make them better off?

The answer would be clear and simple if the standard benefits package were truly comprehensive and fully financed by employers or through the federal tax system. But the President has not chosen this road.

At a minimum, AFGE's goal is to make certain that federal employees pay no more than they do now, and to make certain that their benefits are at least equivalent to what they currently receive. To accomplish this, we must consider both premium contributions and benefit packages which are different from the minimums proposed in the President's bill.

To begin, we must arrive at a definition of what federal employees currently receive. It is not enough to make certain that the dollar value of the government's contribution does not decline; our goal for reform is that through cost controls, the elimination of cost-shifting, and reallocation of resources, each health care dollar will be able to purchase more. Thus we must define both the current cost of FEHBP, as well as the health benefit package which is available through the program.

There is no straightforward way to define the prevailing benefits or costs in FEHBP. Different plans have different benefits and premiums. The premiums charged in Blue Cross and Blue Shield's High Option have been skewed by the risk characteristics of enrollees so much that there is a nearly 250 percent variance between the actuarial value of the plan's benefits and its premiums. Some plans have the "best"

benefits, some have the "best" price relative to benefits (but poor benefits), and some have the "best" price. The truth is there is no "best" plan in FEHBP. What then should be the standard measure, the standard against which we measure any new plan and call it a good deal for federal employees as a group?

Blue Cross Blue Shield Standard Option has the largest concentration of FEHBP enrollment, but it does not have the most comprehensive benefits. Worse, its benefits change from year to year. There is no strict floor on the benefits plans must provide to participate in FEHBP; OPM may require coverage for a category of treatment, but they do not make requirements about the rate or form of indemnity the insurer must provide. AFGE will not worry about the fact that there are some people enrolled in FEHBP who have very low-cost plans with minimal benefits: they will likely pay more as a result of reform, but they will also receive better benefits. But we are concerned with protecting the benefit levels of those in plans with very high benefits. The cost of the benefits included in these "high" option plans is reflected in the government's premium contribution to every plan in FEHBP, so they can not be considered as exceptions or outliers which do not affect the prices of other plans. The concentration of high risk individuals in particular plans also allows other plans to charge lower premiums than they could in a system free of risk segmentation. Thus both the premiums offered and the benefits charged in all plans which enroll federal employees must be considered in defining the current FEHBP benefit.

Dr. Judith Feder, who testified along with OPM Director Jim King before this committee last week, claimed that the actuarial value of the benefits in the President's standard package was roughly equivalent to the average set of benefits offered in FEHBP plans. The differences, she said, were in the types of services covered, with the President's plan placing relatively higher priority on preventive care for both adults and children. Representative Eleanor Holmes Norton (D-D.C.) questioned whether the actuarial value of hospitalization coverage was comparable to that of preventive care, and Dr. Feder implied that it was, but evaded the question by arguing that if federal enrollees chose "low-cost sharing" plans, i.e. HMOs, the problem became moot.

AFGE considers this a crucial issue which cannot be avoided: Federal employees should not be forced to concede complete coverage for hospitalization in order to gain eligibility for prepaid preventive care. And the price of having both should not consign one to the restrictions of an HMO. The current system, with all its flaws, provides a majority of participants with both 100 percent hospitalization, and a variety of preventive services for both children and adults, including dental care. Moreover, the majority of FEHBP participants receive these benefits through fee-for-service plans which they have chosen over other "lower cost-sharing" formats.

AFGE believes that the contention that comprehensive preventive service coverage represents a benefit with roughly equivalent

actuarial value to the last 20 percent of hospitalization coverage is specious. We request that some attempt be made to validate this assertion with empirical data before federal employees are denied what we consider enormously valuable hospitalization coverage. Our own experience suggests that the data will refute this claim.

Federal employees want national health care reform, but we are firm in our belief that the advantages positive reform will bring, such as cost containment, universal coverage, rational allocation of resources, etc.; will allow the federal government to provide federal employees with superior benefits and lower overall costs than currently exist under the FEHBP. Indeed, Dr. Feder, speaking for the Administration at last week's hearing before this Committee, acknowledged that the government expects to spend less on federal employee health benefits as a result of reform. The rhetoric of the Administration as it promotes its plan is that it will lower health care costs for corporations that currently provide comprehensive benefits, making possible an end to the stagnation in wages that working people have suffered over the last 15 years as health care costs have spiraled. The federal government, as an employer, will also see its costs fall. But as the Health Security Act is written, any savings under the new system would apparently accrue to the government. AFGE wants to make certain that if real costs do decline, federal employees benefit from those savings.

Given the complexities in defining the "prevailing" FEHBP benefit, AFGE believes that federal employees should be provided the set of benefits in FEHBP's 1994 Blue Cross and Blue Shield standard option plan, with the government paying 90 percent of the premium for such benefits. The differences between these benefits, and those offered in the Health Security Act's standard package for the "high cost-sharing" option must be made available in a supplemental package. The government's total contribution would then be calculated on an additive basis, as the sum of 90 percent of the weighted average premium in a given standard "alliance" package, and 90 percent of a community-rated premium for a supplemental package which would bring federal employees' coverage up to the level of the 1994 Blue Cross and Blue Shield standard option. In areas where the benefits in the President's standard package are superior to those in the Blue Cross package, federal employees should receive the higher benefit.

The types of benefits which would be included in this supplemental package would be 100 percent inpatient hospital care with no limit on the number of days and no per admission deductible if the hospital were in a plan's network, and 100 percent for such care after a \$250 per admission deductible, if the hospital were outside the network. Fee schedule allowances for adult dental care and lower annual out-of-pocket maxima would also be included. There are other specific benefits and coverage levels included in the Blue Cross plan that vary from the proposed "standard" package which AFGE would be happy to provide to the Committee.

The final explicit safeguard which AFGE believes needs to be included in the legislation involves the impact of variations in premiums by locality. In the short run, we anticipate that there will be large differences in local alliance premiums based on the risk characteristics of local populations. Areas with large concentrations of people who are elderly, poor, under-served, etc. are likely to have premiums which would result in federal employees' having to pay more than they currently do in FEHBP's national plans, despite the seeming improvement in the cost-sharing formula. Ten percent of a higher premium in, say, Washington, D.C., may be higher than 28 percent of the current FEHBP experience-rated premium which applies equally to federal employees throughout the nation. The principle of protecting federal workers so that none is worse off as a result of reform will require special coinsurance rates in these cases.

The benefits in the Blue Cross and Blue Shield plan, along with supplemental cost-sharing adjustments in areas with extraordinarily high local costs, would bring federal compensation closer to that offered by large private sector employers. The government/employer contribution would continue to be lower, both in percentage and nominal terms, but the benefits would be closer to parity. AFGE has made the argument repeatedly, in the context of salaries, health benefits, and retirement benefits, that compensation parity with non-federal employers is vital to the government's effort to recruit and retain highly qualified and highly motivated workers.

The reinventing government initiative, which AFGE has supported, is based on the belief that a workforce that is smaller, but more highly "valued" will succeed in regaining the public's trust and respect. Federal workers who receive better pay and benefits, more training opportunity, more responsibility, more control over their work will be motivated in a variety of ways to create a government that is more efficient and responsive to the people it serves. AFGE shares these goals with the Clinton administration, and we believe that improving federal employees' health care coverage at the same time that national health care reform is undertaken will go far in helping to accomplish them.

The Problems of the District of Columbia

AFGE represents over 55,000 residents of the District of Columbia, who work for both the federal and District governments. We are gravely concerned about the disadvantages we foresee for the City of Washington if health alliances are established on a state-by-state basis. The risk pool for Washington is similar to other large urban centers, and will include an extraordinarily high proportion of people who represent high health care risks: the poor, substance abusers, those exposed to violence, and previously uninsured people whose health status has suffered because they have not had regular access to preventive care. Washington, D.C. has the nation's highest per capita rate of both AIDS and HIV infection. It has the nation's highest infant mortality rate, and one of the highest homicide rates. Other urban areas with similar populations will benefit from inclusion

in an alliance area which brings wealthier and healthier suburban residents together in a more diverse pool. But Washington does not have that advantage.

These issues are of particular concern to AFGE because federal and District of Columbia employees represent a significant majority of the insured population of Washington. We will feel the direct impact of the District's disadvantages.

There is no incentive in the President's bill for either Virginia or Maryland to include a high-cost urban area like Washington, D.C. in their state alliances, even though they would be permitted to do so. Although agreements will undoubtedly be made which will allow residents of the Washington suburbs to utilize the city's excellent health care facilities, the problem remains that Washington's residents will be disadvantaged relative to those in other urban areas, as well as those who work there but live in its suburbs.

Without some provision of subsidies to compensate for the District's disadvantages, all of the social and economic problems which make the Washington population high-risk to begin with will be exacerbated. Since individuals will enroll in plans based on where they reside as opposed to where they work, District residents will be less attractive to employers because the premiums for their care will be higher than those of suburban residents. Unemployment and poverty in the District will increase. Firms will find it economical to locate in the suburbs

rather than the city, and residents who can afford to will also be inclined to leave. The attendant decreases in tax revenues will also exacerbate the City's problems, causing continued funding problems for public schools and other public services.

Other urban areas which include more than one state will face similar difficulties, but the fact that the District is not a state makes it uniquely vulnerable, especially in terms of the restrictions in taxing authority it faces. AFGE believes that in order to avoid the devastating fallout which would result from implementation of the President's bill as it is written, Washington D.C. will need either direct subsidies for its population, or the surrounding states will need financial inducements to include Washington residents in their alliances.

Because of the high concentration of federal employees living in the District, the high premiums which would be charged in Washington if it remains isolated are of concern to all federal employees. The local boundaries drawn for the locality pay system, which reflect commuting patterns, stretch from Baltimore to Saint Mary's County in Maryland to Prince William County in Virginia. This "community" will be paid on the same basis, but is likely to face vastly different health insurance premiums, unlike in the current system. AFGE urges the committee to address the unique disadvantages federal employees living in Washington, D.C. face.

The Politics of Inclusion in Local Alliances

There is an awkward political problem regarding federal employees' health benefits under the Clinton plan: the so-called "standard benefits package" proposed for all Americans is inferior to that provided to Congress, the Executive Branch and members of the Federal Judiciary. If the plan is not good enough for us, why then is it good enough for everyone else? The political symbolism is difficult to ignore. But the problem is solved by acknowledging that the "standard" package represents only a minimum.

AFGE has never supported the idea of maintaining FEHBP as a separate, private program once national health care reform was enacted. On the contrary, we have always supported universal coverage and participation, including federal employees. In fact, we do not support the right of large employers to form their own "corporate alliances" outside the community-based alliance system because we think this allows them to be free-riders, taking advantage of the community's health care infrastructure -- medical education, hospitals, the benefits of subsidized medical and pharmaceutical research, etc.--without having to pay the community rated premiums which will reflect the costs of supporting this infrastructure.

AFGE has no particular affinity for the FEHBP system, and we believe that the Clinton plan holds the potential to be a vast improvement. But we do not want federal employees to suffer in order to maintain the pretense that the President's reform plan will mean everyone in

America will have the same coverage. AFGE would likely have supported such a plan, but that is not what the President has proposed. Thus the standard benefits package must be seen as a minimum, or floor. It reflects the fiscal constraints on the federal government and the competitive restraints on some businesses. Ideally, everyone would have more comprehensive benefits than are specified in the floor, just as everyone would be paid more than the minimum wage. But a variety of political and economic factors have forced the President to be more modest in his benefits package than any of us might have preferred.

Federal employees currently receive health benefits which are superior to those in the standard package, and we are not prepared to receive less under reform. We believe that guaranteeing the benefits set forth in the 1994 Blue Cross and Blue Shield FEHBP plan, with a government contribution to the premium set at 90 percent, is an appropriate solution. It would be a slight improvement over the status quo for the majority of federal employees.

Conclusion

AFGE supports President Clinton's prodigious effort to solve our nation's health care crisis in a way that preserves what is good and eliminates what is wrong. But we will not support the bill if it causes a reduction in health benefits or an increase in costs for federal employees. We consider the general approach to be fair, and are hopeful that if enacted, it will succeed in providing universal coverage, meaningful cost controls, and progressive financing. This concludes my testimony, and I will be happy to answer any questions you may have.

STATEMENT OF
NATIONAL COUNCIL
OF SENIOR CITIZENS

Introduction

Good morning, Mr. Chairman, members of the Subcommittee. It is a pleasure to be here today. My name is Daniel Schulder. I am the Legislative Director of the National Council of Senior Citizens (NCSC). NCSC represents over five million older and retired Americans nationwide through our 5,000 affiliated clubs and Councils. The National Council was founded in 1961 to lead the fight for Medicare. After its enactment—an event we considered to be the first step in the creation of a universal national health care system—the Council continued its work on health reform. At the same time, we expanded our commitment to programs for older workers, transportation, housing, civil rights and Social Security and pension protections. Our work is not just for today's retirees, but also for current workers who will one day enjoy the fruits of their labor and for younger persons not yet in the workforce.

Health Principles

Over the decades, the National Council has debated which way this nation should provide health care to all its citizens. After careful consideration of many different approaches, our membership and General Policy Board adopted a set of health reform principles. The principles are used by our officers and legislative staff to determine if specific legislation merits the support of the National Council. The health reform goals of this organization and America's seniors are incorporated in these principles. They are:

- Universal coverage, with everyone in the same system.

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- Comprehensive benefits so that all medically necessary services will be provided to all without multiple tiers of benefits based on income, age or other extraneous factors.
- Costs must be controlled throughout the system.
- Financing must be fair and progressive.
- Cost sharing must not create barriers to receiving care and must not be relied upon to finance the system.
- Quality must be strengthened with consumer protections.
- Health planning must be undertaken to allow all our citizens equal access to high-tech medicine.
- Patients' rights must be spelled out to guarantee the timely delivery of services.
- The Federal government and states must oversee the program to ensure a strong role for consumers in the administration of the program.
- Finally, whatever system is adopted must point the way towards a single-payer system.

Single-Payer

Mr. Chairman, the health system that best incorporates these principles is the single-payer approach embodied in the legislation introduced by Congressman Jim McDermott (D-Wash.) and Senator Paul Wellstone (D-Minn.).

Single-payer provides a sensible approach to most of our health care problems. It will reach every resident of this country and guarantee that their health care needs will be met. It will be paid for fairly through a progressive income and business tax system with those who can afford paying a fair share, while lower-income people will not see their tax burden increased. Under the Wellstone/McDermott bills up to 90 percent of all Americans will see their overall health care spending decrease.

Single-payer allows us to finally get a solid handle on costs that are spinning out of control. (NCSC believes that the current trend showing slower growth in overall health spending is a cynical manipulation of the system by the insurers and providers of health care to

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lull us into believing there is no financial crisis.) Only through system-wide cost controls will we be able to put an end to providers being able to pit one group against another (e.g., raising private pay rates to make up for falling Medicare and Medicaid rates).

Single-payer will expand benefits for all Americans. It will allow us to provide an extended array of preventive care services to keep people healthy, prescription drugs to maintain that health, and long-term care services keyed to community and home-based supports rather than to institutional services.

Finally, single-payer keeps the private health delivery system intact and it builds on the strengths of that system.

Passage of a single-payer system is the ultimate goal of the National Council. However, our arrival at that goal may not be as direct as we might wish.

President Clinton's Legislation

As you know, the President of the United States has introduced a comprehensive plan to cover all Americans. We examined the Clinton bill in the context of our own health care principles. We have found many reasons for seniors to support the Clinton health proposal.

Universal coverage guaranteed by 1998 is a key reason the National Council believes that H.R. 3600 advances the health reform debate. No other health care proposal, other than single-payer, comes close to meeting this important goal.

Strong cost containment: If we as a nation cannot hold down the spiraling growth in private health care expenditures, we will never be able to control Medicare and Medicaid costs—leaving us unable to achieve any meaningful, long-term deficit reduction or needed domestic investments.

Under H.R. 3600, Medicare is strengthened with the addition of a prescription drug benefit with capped out-of-pocket costs. Balance billing is finally eliminated under Medicare. NCSC fought for many years, both here in Congress and in State Houses across the nation, to have this onerous and regressive cost-sharing provision removed from the Medicare program.

Pre-Medicare or "early" retirees are covered. While some in Congress may see this as a boon to those corporations which now provide retiree health benefits, it is actually a necessary component for reaching universal coverage. Of the ten million pre-Medicare retirees, only about forty percent have any business-provided health insurance. Only four percent of all U.S. companies provide any retiree health benefits. This means six million older Americans are either buying individual insurance policies themselves, are utilizing government assistance or are going without such protection. The pre-Medicare retiree benefit is fundamentally not a business benefit, but a help to retired workers and their families. Many of these people were "down-sized" out of the workplace. They would have continued working had their employer not told them they would get either a pension check or an unemployment check.

This President has taken leadership to acknowledge that meeting chronic care needs are as important as acute services. The creation of a non-means-tested long-term home and community-based care program for citizens of all ages takes the crucial first step of meeting chronic care needs that increase with age across the nation.

This same commitment to seniors' health needs of America cannot be found in the Cooper/Breaux bill which will eliminate all federal support for long-term care forcing the states to pick up the difference. It cannot be found in the Michel/Lott bill which simply cuts reimbursement rates for Medicare making it harder for beneficiaries to find a provider. These pieces of legislation, and similar efforts, only take from Medicare and offer nothing in exchange.

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The National Council strongly believes that the useful debate should not be between the so-called "Clinton-lite" plans and Clinton but rather between H.R. 3600 and H.R. 1200. As the polls show, it is not a matter of how far the American people want to go, it is a question of how far Congress is willing to hold us back from truly effective solutions.

This does not mean the National Council believes the Clinton bill to be without flaw. There are key improvements we would like to have made to the bill as drafted.

In order to create a single-tiered health care system and to eliminate the perception that older citizens could be treated as second-class medical citizens under H.R. 3600, we believe Medicare beneficiaries should be given the option to join a health alliance plan or return to Medicare during the open enrollment season. If a senior opts into the health alliance system, then Medicare should be required to pay the 80 percent average-weighted premium like Medicaid, rather than Medicare paying to the Alliance what it would have paid had the beneficiary stayed in Medicare. The health alliance premium for an older citizens must, like their younger counterpart, be community-rated if we are to purge a major evil of the current insurance system of risk adjustments of premium by age.

We are also concerned about the ability of Medicare to absorb another \$124 billion in cuts. In order to mitigate these changes and stop the current trend of physicians turning away Medicare beneficiaries, we believe private-pay rates and Medicare rates should be linked together. By legislating that Medicare rates could not be lower than seven percent of the average reimbursement for a geographic location, Congress would ensure providers would not lack an economic incentive to see Medicare patients. Also, if the private-sector cost containment were more successful than anticipated, Medicare growth would fall more quickly. We also

believe that the Congress should consider a hard-nosed anti-discrimination clause in H.R. 3600 assuring that Medicare beneficiaries will not lose access because of lower payments to providers.

In fairness, since the Clinton program provides financial protections to those at 150 percent of poverty or below, the Qualified Medicare Beneficiary (QMB) eligibility thresholds should be raised to this level. We would also like to see a federal minimum benefit level specifying services established for the long-term home and community-based care program in order to establish a uniform set of support services throughout the states. The eligibility requirement should also be reduced from three activities of daily living to two based on a care manager's assessment of need.

Single-Payer Option

Mr. Chairman, the National Council believes that national health reform debate now centers on H.R. 3600. As I said earlier, we want that debate to continue and to incorporate the benchmarks established by the single-payer proposals. We know that a single-payer system will be adopted by this nation one day, and we are going to do all we can to further that day along. That is one reason why we are going to be fighting very hard for Congress to pass the single-payer state option the President included in his bill.

Several states are already interested in adopting a single-payer system and the Federal government should not prevent their doing so. The Congress of California Seniors, as you know, Mr. Chairman, is very much involved in the California Health Access campaign to pass a single-payer initiative in your home state. Canada did not adopt a its successful single-payer structure overnight, rather it was enacted one province at a time. If that is what it will take to demonstrate the political commitment for this approach to our federal legislators then we are

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prepared to work for single-payer, state-by-state. What we will not support is a retreat from basic assumptions of the President's proposal. That would betray the principles demanded by our members.

Goals of the National Council of Senior Citizens

This organization has not backed away from our single-payer support. We support the Clinton bill because we see the Clinton bill as laying the foundation of a national and efficient system of health care. We will be working with the Congress and this subcommittee to bring the Clinton plan in line with as many single-payer principles as we possibly can. We will then use every resource we have available to ensure the passage of a progressive health reform package. We will oppose any and all legislation that does not meet our principles and sets back the cause of senior health care and the health needs of all citizens.

With your help, our members' hard work, and God's blessing, we will enact the most fundamental restructuring of the health care system in our nation's history. Thank you.



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